

**CULTURAL PRACTICES AND BELIEFS AFFECTING HIV AND AIDS MANAGEMENT  
AMONG TSONGA PEOPLE IN BUSHBUCKRIDGE**

by

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**DECLARATION**

I Lynette Fanisa Baloyi declare that “**CULTURAL PRACTICES AND BELIEFS AFFECTING HIV AND AIDS MANAGEMENT AMONG TSONGA PEOPLE IN BUSHBUCKRIDGE**” is my original work. I declare that all sources that I have used or quoted have been acknowledged through reference. This work has not been submitted for any other degree at any other institution of higher learning.

A handwritten signature in black ink, reading "LF Baloyi", is written over a horizontal line.

Signature

\_\_23 September 2019\_\_

Date

## **DEDICATION**

I am dedicating this thesis to the following:

- My late dad, Phillip Charles Baloyi whose love for education was immeasurable,
- My mother Busisiwe Mabel Baloyi for caring and supporting schooling,
- My one and only late brother Sydney Baloyi for encouraging me through his eloquence in English,
- My late sister Sponono and my three sisters Sonty, Zodwa, Zandy and my only child, Carol and her family.

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For the rest of the period when I was busy with this work, I have approached different people who contributed a lot and supported me to continue doing this work. It is not possible to list all of them here. However, I would like to send my special thanks to the following:

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## ABSTRACT

This ethnographic study explored and described practices and beliefs that may have an impact on the management of HIV and AIDS among Tsonga people in Bushbuckridge. Data was collected through face to face in-depth individual interviews with 19 key informants who are highly knowledgeable about the Tsonga culture. The researcher used ethnographic content analysis to analyse data. Findings indicated that language, rituals, beliefs related to the origin of diseases, traditional healers, and tattoos are among Tsonga cultural practices and beliefs that have an impact on management of HIV and AIDS. Some of the practices increase the risk of HIV infection while some assist in the reduction of the risk of HIV infection. Based on the findings of the study and literature, the researcher managed to develop a contextual, cultural approach model for HIV and AIDS management for Tsonga people in Bushbuckridge. The model development was guided by Leininger theory of culture, care, diversity, and universality. To organise the model, the researcher used CIPO model to guide the elements of the cultural approach model. Though the model takes into consideration global and national context, the main focus was the local context in particular Bushbuckridge. The success of this model is dependent on the availability of knowledgeable healthcare practitioners, relevant resources and engaged community structure. The process of the model includes Cultural Care Preservation, Cultural care Accommodation, and Cultural care Re-patterning. The expected output of the model is modification of HIV risky cultural practices, improved health-seeking behaviour, reduction of new HIV infections and reduction of HIV and AIDS-related deaths. Based on the study outcomes, the researcher makes several recommendations in relation to implementation of the model, Nursing Practice and Education, and further research. The study has contributed to the body of knowledge in relation to cultural practices and management of HIV and AIDS. The model can be utilised to enhance nursing education and practice and further research.

Key concepts: *Acquired Immune Deficiency Syndrome, Culture, Cultural practices, Human Immunodeficiency Virus, Management, Tsonga.*

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## **LIST OF ABBREVIATIONS**

ABC	Abstain Be faithful Condomise
AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretrovirals
CIPO	Context Input Process Output
HBCs	Home Based Care workers
HIV	Human Immunodeficiency Virus
IDP	Integrated Development Plan
NSP	National Strategic Planning
PHC	Primary Health Care
PMTCT	Prevention of Mother To Child Transmission
SA	South Africa
SANAC	South African National AIDS Council
STIs	Sexually Transmitted Infections
TB	Tuberculosis
THP	Traditional Health Practitioners
UNAIDS	United Nations Programme on HIV/AIDS
WHO	World Health Organization



## **CHAPTER ONE: ORIENTATION OF THE STUDY**

### **1.1 INTRODUCTION**

This study focused on Tsonga cultural practices and beliefs that may influence transmission and management of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) among Tsonga people in Bushbuckridge, which is part of Mpumalanga Province of South Africa. South Africa is a country that is mostly affected by HIV and AIDS pandemic globally (Abdool Karim & Abdool Karim 2010: 61; Bezuidenhout 2013: 240; Ngcobo 2013: 20). By the year 2016, almost 7.1 million people were confirmed to be living with HIV in South Africa (Department of Health 2016: 6). Almost 3.7 million people living with HIV were on antiretroviral treatment in the same year. Every year, there are almost 270 000 new HIV infections. Despite the high number of people on antiretroviral therapy (ARV), several people are still dying from HIV and AIDS-related conditions. A total of 150 375 people died of HIV and AIDS-related diseases in 2016 (Department of Health 2016: 3). The number is increasing annually.

This chapter provides an overview of the study. It also provides the background to the research problem, the problem statement, purpose, objectives, and research question of the study. The chapter further highlights the significance of the study; defines keywords utilised in this study, methodology, and the thesis outline according to chapters.

### **1.2 BACKGROUND TO THE RESEARCH PROBLEM**

The campaign against HIV and AIDS is a global concern. The World Health Organisation (WHO) theme for fighting HIV and AIDS for World AIDS Day for the years 2011- 2015 was aimed at "Getting to Zero new HIV infections, Zero Discrimination, and Zero AIDS-related deaths" (Joint United Nations Programme on HIV and AIDS [UNAIDS] 2015: 8, 21). The "Zero" was embraced in goal number one of the South Africa National HIV & AIDS, Sexually Transmitted Infections (STIs) and Tuberculosis (TB) Strategic Plan (NSP) 2017-2022, focusing on the acceleration of prevention to reduce new HIV infections (Department of Health 2016: XIV). South African government saw the need to accelerate efforts to achieve this commitment by focusing on social and structural issues which were identified as key drivers of HIV and AIDS epidemic (Department of Health

2016: 5). This was done through implementation of measures such as the “*Abstain, Be faithful, Condomise* (ABC)” campaign, the introduction of Health Provider Counselling and Testing, the offering of free circumcision at government hospitals to reduce the risk of Sexually Transmitted Infections (STIs) and HIV, the provision of free condoms and antiretroviral drugs to improve the health status of those that are infected and reduce unnecessary deaths are in place (Evian 2011: 5, 31).

Though there are measures in place to fight HIV, this pandemic continues to affect South Africans directly or indirectly (Vasuthevan & Mthembu 2014: 139). The preventive strategies “have failed in most of Africa” to curb the spread of HIV (Buzuidenhout 2013: 241). According to Bezuidenhout (2013: 240), there are not enough signs that this pandemic is being eradicated. The HIV prevalence in South Africa is not uniform in all areas and also among certain cultural groups. This may be related to diverse cultural practices in South Africa. According to van Dyk (2012: 231), some of the harmful traditional behaviours such as the community’s view regarding multiple sexual partners, cleansing rituals and wife inheritance of a deceased brother may be HIV risky. The aspects of considering culture in the management of HIV and AIDS was emphasised by van Dyk (2012: 231) mentioning the importance of taking into account local customs and traditional cultural beliefs when designing HIV prevention programmes. Van Dyk (2012: 217) further stated the need for conducting in-depth and focused studies focusing on a diversity of the populations and cultural groups in HIV prevention and caring for people living with HIV and AIDS in order to design programs that are culturally relevant for the prevention and combating of the disease.

This approach may assist in the reduction of HIV prevalence in South Africa as currently, HIV and AIDS thus continue to be a serious challenge for South Africa in general, and the Mpumalanga province in particular.

### **1.3 PROBLEM STATEMENT**

According to NSP 2017-2022 Mpumalanga (where Bushbuckridge is found) is the second province at 15% (Department of Health 2016: 7). The majority of people staying in Bushbuckridge are Tsonga. Bushbuckridge sub-district, which is under Ehlanzeni district is one of the areas that are heavily burdened with HIV (Department of Health 2016: 12).

According to the statistics of Bushbuckridge sub-district for the year 2018/2019 there were 3.659 clients of aged 15 years and older who tested positive for HIV. This happened regardless of the programmes which are implemented as recommended by the Department of Health, such as the free provision of condoms, free HIV testing, free antiretroviral treatments, and awareness campaigns. The situation makes one assume that there might be some cultural issues which might be affecting the management of HIV among Tsonga people in Bushbuckridge. Though there is evidence that cultural practices and beliefs have an impact on the prevention, transmission, and treatment of HIV, there is no documented study which focused on Tsonga cultural practices and beliefs in relation to HIV management in Bushbuckridge.

#### **1.4 PURPOSE OF THE STUDY**

The purpose of the study was to gain an in-depth understanding of cultural practices and beliefs that may affect the management of HIV and AIDS among Tsonga people in Bushbuckridge in order to develop a contextual cultural approach model for HIV and AIDS management.

#### **1.5 RESEARCH OBJECTIVES**

The objectives of the study were to:

- Explore and describe Tsonga cultural practices and beliefs that may increase the risk of HIV infection among Tsonga people in Bushbuckridge.
- To develop a contextual, cultural approach model for HIV and AIDS management for Tsonga people in Bushbuckridge.

#### **1.6 RESEARCH QUESTIONS**

The following research questions guided the study:

- What are the Tsonga cultural practices and beliefs that may have a negative impact on the management of HIV and AIDS among Tsonga people in Bushbuckridge?

- What can be done to enhance the management of HIV and AIDS among Tsonga people in Bushbuckridge?

## **1.7 SIGNIFICANCE OF THE STUDY**

The existence of new HIV infections and poor progress in fighting HIV in Bushbuckridge has shed light into the gaps that exist in the clinical facilities and the community regarding preventive messages for HIV. This resulted in conducting a study on HIV risky cultural practices among the Tsonga community of Bushbuckridge. This study revealed that there are numerous HIV risky cultural practices identified during the study. This study has been of social and clinical significance in Bushbuckridge, and findings may be transferable to similar cultural groups. The study resulted in the development of A cultural approach model for management of HIV and AIDS among Tsonga people in Bushbuckridge. The model can be utilised by Health care professionals to mitigate HIV risky Tsonga cultural practices and beliefs. The model can also be utilised to address community regarding behaviour modification in the quest to fight against HIV with specific reference to HIV risky cultural practices. The findings of the study and the model developed are of significance as it addresses problems of prevention of HIV in the clinical area and habits or customs of this cultural group. It is also in support of the global strategy as a preventive measure of striving for Zero new HIV infections (UNAIDS 2011: 9).

## **1.8 DEFINITIONS OF KEY CONCEPTS**

The following are the definitions of the key concepts used in this study:

### **1.8.1 Acquired Immune Deficiency Syndrome (AIDS)**

It is an acronym referring to a disease which is acquired and not inherited, caused by a virus which invades and attacks the body 's immune system making the body failing to protect itself from common and serious infections (van Dyk 2012: 492).

### **1.8. 2 Beliefs**

This is a situation where one accepts that (something) is true or reliable even without proof (Hornby 2017: 8).

### **1.8.3 Cultural practices**

Cultural practices refer to explicit and/or implicit behaviour informed by cultural beliefs, values, social relationships, structures and systems that may or does promote the spreading of HIV and AIDS (Mogotlane, Chauke, Matlakala, Mokoena & Young 2014: 22).

### **1.8.4 Human Immunodeficiency Virus (HIV)**

Human Immunodeficiency Virus refers to the virus that weakens immunity and eventually leads to AIDS (WHO 2015: 12).

### **1.8.5 Management**

Management refers to a process of activities carried out in order to achieve organizational goals through utilising human, financial, physical, and informational resources (Smit, Cronjé, Brevis & Vrba 2007: 123). In this study, management means prevention of HIV transmission, care, and support of people living with HIV and AIDS.

### **1.8.6 Tsonga**

Tsonga people are one of the African groups found in South Africa, Mozambique, eastern and southern parts of Zimbabwe as well as some parts of Swaziland and Zambia (Mathebula 2013: 8). In this study, Tsonga will mean an adult of Tsonga ethnic group residing in Bushbuckridge.

## **1.9 THEORETICAL FOUNDATION OF THE STUDY**

This section covers the theoretical framework, paradigm, research approach and research design that guided the study.

### **1.9.1 Theoretical framework**

The study was guided by Leininger theory of Culture Care Diversity and Universality. The theory emphasises providing culturally-congruent care that is beneficial and suitable and be useful to the client, family, or culture group healthy lifeways (Fawcett 2000: 512). The researcher has chosen this theory because it guided provision of culturally congruent, competent, and safe care in a growing multicultural world.

Figure 1.1 shows the structure Leininger theory of culture care diversity and universality.



Figure 1.1 Leininger theory of culture care diversity and universality (Leininger 1991: 28)

This theory focuses on the fact that different cultures have different caring behaviours and different health and illness values, beliefs, and patterns of behaviours. The theory focuses on knowing and understanding different cultures with respect to health-illness caring practices, beliefs and values with the goal to provide meaningful and efficacious care services to people according to their cultural values and health-illness context. (Wayne 2014: 5).

Though Leininger theory of Culture Care Diversity and Universality have several assumptions, because the researcher aims to gain an understanding of cultural practices of Tsonga people which may influence the management of HIV in order to develop a contextual, relevant model for integrating Tsonga cultural practices in HIV/AIDS management, the researcher concentrated on the following four assumptions: (i) Different cultures perceive, know, and practice care in different ways, yet there are some

commonalities about care among all cultures of the world (ii), Nursing care will be culturally congruent or beneficial only when the clients are known by the nurse and the clients' patterns, expressions, and cultural values are used in appropriate and meaningful ways by the nurse with the clients; (iii) Values, beliefs, and practices for culturally related care are shaped by, and often embedded in, "the worldview, language, religious (or spiritual), kinship (social), political (or legal), educational, economic, technological, ethno-historical, and environmental context of the culture. (iv) If clients receive nursing care that is not at least reasonably culturally congruent (that is, compatible with and respectful of the clients' lifeways, beliefs, and values), the client will demonstrate signs of stress, noncompliance, cultural conflicts, and/or ethical or moral concerns (Leininger 1991: 28).

To curb the state of noncompliance to HIV management by Tsonga people, as the objectives of the study led to identifying cultural practices which may influence the management of HIV and AIDS, the researcher also considers the three cultural care congruent modalities of care by Leininger (1991: 30) relevant. The three modalities are (i) cultural care preservation which will be applied to those practices which enhance HIV management; (ii). Cultural care accommodation or Negotiation which were applied to those neutral practices which have neutral influence in HIV management. (iii) Culture care re-patterning or Restructuring will be done in order to assist Tsonga people in changing or restructuring the practices which fuel the spread of HIV and hinders the effective provision of treatment and care (Leininger 1991: 30).

The theory enabled the researcher to gain an understanding of the cultural behaviour (what members of the culture do), cultural artefacts (what people make and use) and cultural speech (what people say) cultural care beliefs, values and lifestyle of Tsonga people in Bushbuckridge which guided the development of cultural congruent model for HIV and AIDS management among this community.

### **1.9.2 PARADIGM**

Paradigm refers to "fundamental conceptions of how to research in a specific field with consequences on the levels of methodology and theory" (Flick 2014: 540). Paradigm is

also defined as a way of looking at natural phenomena that guides one's approach (Polit & Beck 2008: 761). It is also a "particular way of viewing a phenomenon in the world" (Grove, Burns & Gray 2013: 702). It is a philosophical stance of the researcher providing a set of beliefs guiding action (Grove, Gray & Burns 2015: 324). In this study, the researcher used a constructivist paradigm. Constructivist believe that knowledge is constructed as the results of the social and cultural determinants. It emphasises the importance of interactions with others and the environment influence as the source of knowledge construction which will determine a people's beliefs and behavior (Bryman, Bell, Hirschsohn, Dos Santos, du Toit, Masenge, Van Aardt & Wagner 2014: 15). This is more relevant in this study which focused on the cultural practices and beliefs of Tsonga people in Bushbuckridge. The research paradigm determines the research approach to be followed.

### **1.9.3 Research Approach**

As the researcher aimed at to gaining an in-depth understanding of cultural practices and beliefs that may affect the management of HIV and AIDS among Tsonga people in Bushbuckridge, qualitative research approach was considered most relevant. This is because qualitative studies aim at an in-depth study of a phenomenon in a real-life situation to understand people's beliefs, actions, events where the researcher is subjectively involved in understanding the findings in a specific context (Brink et al. 2018: 104). More information regarding qualitative approach is presented in chapter 3. Research approach influences the choice of research design.

### **1.9.4 Research Design**

The researcher used ethnographic design because this design focuses on the role of how culture influences the ways of life of a particular community (Grove et al. 2015: 502). The design was more relevant because the researcher is focusing on the cultural practices and beliefs of Tsonga people in Bushbuckridge. Detailed information regarding ethnographic design is provided in chapter three. Research design determines the choice of research methodology.



## **1.10 RESEARCH METHODOLOGY**

The study was conducted into two phases. The first phase was a situational analysis which involved face to face in-depth individual interviews with key informants to gain an in-depth understanding of cultural practices and beliefs that may affect the management of HIV and AIDS among Tsonga people in Bushbuckridge. Phase two was informed by the findings of situational analysis and focused on the development of a contextual cultural approach model for HIV and AIDS management. The methods followed during these phases are discussed thoroughly in chapter 3. Ethical principles were considered during all the phases of the studies.

## **1.11 MEASURES TO ENSURE TRUSTWORTHINESS**

Trustworthiness is an approach used to ensure the scientific strength of qualitative research (Grove et al. 2015: 513). To ensure trustworthiness, the researcher adhered to the following criteria identified by Lincoln and Guba 1985 described in Grove et al. (2015: 513): credibility, dependability, confirmability, and transferability. Detailed information regarding the criteria and how they were ensured in this study is provided in chapter three.

## **1.12 ETHICAL CONSIDERATIONS**

Ethics is defined as the moral principles governing or influencing conduct (Concise Oxford English Dictionary 2011: 490). To remain ethical throughout the study, the researcher observed the following ethical issues in line with Creswell and Poth (2018: 55): permission, autonomy, informed consent, confidentiality, privacy, anonymity, beneficence, non-maleficence, voluntary participation, and scientific integrity. Details regarding the steps taken to adhere to the above listed ethical principles are discussed in chapter 3.

## **1.13 STRUCTURE OF THE STUDY**

The thesis consists of seven chapters which are composed of several sections. A brief outline of each chapter is offered to guide the readers on the content of this thesis.

**Chapter one** gives a general introduction to the study, background including the problem statement. It provides the aim, objectives, and research question of the study, and

definition of the key concepts used in the study. A brief description of the theoretical grounding of the study including theoretical framework, paradigm, and research approach is provided. The methodology, ethical aspects and measures to ensure trustworthiness is highlighted.

**Chapter two** focuses on the literature review. The focus of literature review was on cultural practices affecting the management of HIV and AIDS in different communities. The chapter highlights literature search strategy, appraisal of identified literature and themes which emerged from literature reviewed.

**Chapter three** provides detailed information on the research paradigm, approach, design, and methodology for Phase one of the study, which is situational analysis. It describes the study site, sampling method, data collection, and analysis, measures followed to ensure trustworthiness and how ethical principles were adhered to. Section two of the chapter provided a detailed process followed for model development.

**Chapter four** presents the biographical data of the key-informants. It further provided the research findings according to the superordinate themes, themes and subthemes emerged from data analysis. The results are supported by excerpts from the key informants' transcripts.

**Chapter five** presents the discussion and interpretation of the findings in relation to the existing literature. It focuses on the how the cultural practices and beliefs of Tsonga people affect the management of HIV and AIDS in comparison to what is mentioned in existing literature about the cultural practices and beliefs in relation to HIV and AIDS.

**Chapter six** provides an overview of the developed cultural approach model for HIV and AIDS management. It provides the overall description of the structure of the model. It further provides the assumptions and the purpose of the model.

**Chapter seven** presents the summary of findings in relation to research questions and objectives, a summary of a contextual, cultural approach model for HIV and AIDS management, limitations of the study, contributions of the study, recommendations and the conclusions.

## **1.14 CONCLUSION**

This chapter provided the orientation to the study, the research problem, research purpose, objectives, and research questions. It also introduced the theoretical foundation of the study and research methodology. The next chapter will present the literature reviewed.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 INTRODUCTION**

The previous chapter outlined the orientation of the study. This chapter focus on a review of relevant literature. The review was intended to identify and reveal African cultural practices which affect the management of HIV and AIDS. Literature review is defined as a systematic and explicit approach to the identification, retrieval and bibliographic management of independent studies to locate information on a topic, synthesizing conclusions, identifying areas for future studies, and developing guidelines for clinical practice (Brink, van der Walt & van Rensburg 2018: 58). The chapter provides search protocol and strategy, themes that emerged from literature appraisal, identified gap in literature, the scope of literature review, thematic areas reviewed and systems theory.

### **2.2 SEARCH PROTOCOL**

The researcher followed Porritt, Gomersall and Lockwood (2014: 47) steps to guide literature search. The steps include: Formulation of an aim, review objective and relevant review question; Identification of keywords for search; identification of inclusion and exclusion criteria; searching of literature from different sources; appraisal of literature; analysis, synthesise and summarising the data, presentation of findings, conclusions and recommendations where applicable.

#### **2.2.1 Formulation of an aim, review objective and relevant review question**

The aim of the search was derived from the study purpose but generalised to a different context and read as follows: To gain an understanding of cultural practices and beliefs that may affect the management of HIV and AIDS. The search objectives were as follows:

- To identify cultural practices and beliefs that may increase the risk of HIV infection.
- To identify existing measures for mitigating cultural practices and beliefs that negatively affect the management of HIV and AIDS.

The following research questions based on the objectives guided literature search:

The study was guided by the following research questions:

- What are the cultural practices and beliefs that may increase the risk of HIV infection?
- What is done to mitigate cultural practices and beliefs that negatively affect the management of HIV and AIDS?

### **2.2.2 Keywords and Search Terms**

Keywords are useful for searching relevant literature which will be useful in forming the foundation of the study (David 2015: 51). The following keywords guided literature search: Acquired Immune Deficiency Syndrome, AIDS, beliefs; beliefs, Culture, cultural beliefs, Cultural practices, customs, ethnography, Human Immunodeficiency Virus, HIV, HIV infection, HIV transmission, HIV risk behaviours, management, mitigation and rituals.

### **2.2.3 Inclusion Criteria**

To avoid an excessive amount of literature and also to use outdated sources which might not be useful considering the current HIV management process, the researcher has focused on the literature searched published from 2003 to 2019. The articles related to the research topic and aim was prioritised, followed with a reflection of most of the identified keywords. The researcher also included studies researched in English following either qualitative, quantitative, and mixed-method designs. Ethnographic studies focusing on HIV were also highly considered.

### **2.2.4 Search Strategy**

The researcher conducted a systemic search to get relevant sources of literature. A systematic search focus on using multiple techniques to get relevant sources (Booth, Papaioannou & Sutton 2012: 71). The researcher first asked the expert in the HIV field about the possible sources which are available in relation to HIV and culture. The researcher further requested the Librarian for the Department of Health studies to search on different website which the University of South Africa has access to. In order to assist the librarian in searching, the researcher gave the librarian the title of the study which is “*cultural practices and beliefs affecting HIV and AIDS management among Tsonga people in Bushbuckridge*” and the keywords listed in the previous section.

The researcher was guided by the keywords using Boolean operators such as 'AND,' 'OR' and 'NOT' (Fink 2005: 28). Sources of literature were research articles published in different countries about cultural issues as a driver of spreading the virus in the era of HIV and AIDS. Countries such as America for African Americans, African countries found in Sub-Saharan Africa such as Tanzania, Kenya, Malawi, Zambia, Zimbabwe, Swaziland including South Africa for different cultural groups had scientific evidence about harmful cultural practices influencing the spread of HIV. Textbooks and published materials from the South African health department were also used, such as information from the National Strategic Plan of the Department of Health of the year 2017. A wide range of journals such as Biomed Central Complementary and Alternative Medicine, Journal of Social Aspects of HIV/AIDS, Culture, Health & Sexuality and Global Health were read to locate relevant sections about the title of this study. These and dissertations including many other journals were read in search of the literature to identify HIV risky and detrimental cultural practices perpetuating the spread of HIV in different communities thus resulting in detrimental effects towards the health of people.

## **2.3 APPRAISAL AND SYNTHESIS OF LITERATURE**

The importance of literature appraisal is to exclude studies of low quality and those whose results compromise rigor (Porritt et al. 2014: 48). After an initial reading of literature and excluding the irrelevant ones, the process of thorough review of the relevant literature guided by the following steps of critical literature appraisal, as described by Botma, Greeff, Mulaudzi and Wright (2015: 232).

- Stage 1: The researcher read each article several times to get an understanding of what is written in the article.
- Stage 2: After understanding the contents, the researcher made notes about important aspects highlighted in the article.
- Stage 3: The researcher went through the notes to highlight the themes emerging from the literature.
- Stage 4: The researcher searched the connections across the emergent themes
- Stage 5: Finally, the researcher developed final themes and sub-themes

## 2.4 THEMES THAT EMERGED FROM LITERATURE APPRAISAL

Five themes with several sub-themes have emerged from appraisal and synthesis of the literature. Summary of themes and sub-themes are displayed in table 2.1.

**Table 2.1 Summary of themes and sub-themes**

Themes	Sub-themes
<b>2.4.1 Aspects related to sickness and health</b>	<b><i>2.4.1.1 Health seeking behaviour and belief in the traditional healers.</i></b>
	<b><i>2.4.1.2 Witchcraft.</i></b>
	<b><i>2.4.1.3 Ancestral beliefs.</i></b>
<b>2.4.2 Aspects related to marriage</b>	<b><i>2.4.2.1 Payment of bride price (lobola).</i></b>
	<b><i>2.4.2.2 Early marriage in women.</i></b>
	<b><i>2.4.2.3 Polygamy.</i></b>
<b>2.4.3 Gender issues</b>	<b><i>2.4.3.1 Socialisation of children.</i></b>
	<b><i>2.4.3.2 Freedom of men.</i></b>
	<b><i>2.4.3.3 Patriarchy.</i></b>
	<b><i>2.4.3.4 Submissiveness of African women.</i></b>
	<b><i>2.4.3.5 Position and status of African women.</i></b>
<b>2.4.4 Aspect related to procreation and childbearing</b>	<b><i>2.4.4.1 Procreation.</i></b>
	<b><i>2.4.4.2 Infertility management.</i></b>
	<b><i>2.4.4.3 Breastfeeding practices.</i></b>

	<b><i>2.4.4.4 Traditional birth attendants and home delivery.</i></b>
<b>2.4.5 Rituals</b>	<b><i>2.4.5.1 Initiation.</i></b>
	<b><i>2.4.5.2 Widow cleansing.</i></b>
	<b><i>2.4.5.3 Widow Inheritance (Wife inheritance).</i></b>
<b>2.4.6 Sex and sexuality</b>	<b><i>2.4.6.1 Lack of discussion about sexuality issues</i></b>
	<b><i>2.4.6.2 Taboos related to sexual information</i></b>
	<b><i>2.4.6.3 Dry sex</i></b>
	<b><i>2.4.6.4 Multiple Concurrent partnerships</i></b>

## **2.4.1 Aspects Related to Sickness and Health**

This theme focuses on the way people view sickness and causes of the illness. It has three sub-themes, namely: Health seeking behaviour and belief in traditional healer, Witchcraft and Ancestral beliefs.

### ***2.4.1.1 Health seeking behaviour and belief in traditional healer***

The belief in seeking health among some people in sub-Saharan Africa is that of approaching traditional health care practitioners when there is a disease or illness and visiting allopathic clinical services (Audet, Ngoben & Wagner 2017: 1). Traditional medicine is widely used in Africa including South Africa (Mogotlane et al. 2014: 40). Many people prefer to consult traditional healers for several reasons (McClellan 2012: 53). Some of the reasons are that they (traditional healers) are easily accessible, they speak the local language, they are compassionate, and they give themselves time to explain the underlying cause of disease and treatments (Audet et al. 2017: 1). The traditional model



is also used by people who believe that illness has to do with witchcraft or ancestors and traditional healer can help in the prevention of illness, diagnosis, treatment, and maintenance of well-being (McClellan 2012: 36). HIV infection is caused by a virus, not witchcraft (Mogotlane et al. 2014: 362). Until such time when people's health-seeking behaviours are addressed in line with HIV pandemic, people usually delay consulting clinics or hospitals. In Swaziland, delay in the consultation was attributed to belief in traditional healers, herbalists, spiritualists, or use of specific herbs (Nxumalo 2014: 33).

According to Van Dyk (2012: 250), people have different beliefs when it comes to illness and cure for illness as illness may be a result of a malicious spell or punishment or as a result of one having transgressed ancestors. On the other hand, if one is healthy, it is a sign of supernatural favour. Even though Africans go for western treatment, it is still necessary for health care practitioners to provide health education that can address patients' health or illness beliefs. The other issue is that ordinary people or lay people believe that if they are not having pain, they are healthy. This means that by the time they go for medical consultation, it is usually very late (McClellan 2012: 36). Unfortunately, when one is HIV positive one can remain well without pain for many years up to twenty years for slow progressors (Mogotlane et al. 2014: 352). Thus, a person who remains without symptoms or pain can spread HIV being unaware. This can be worsened by using natural remedies (McClellan 2012: 36) leading to delay in consultation due to a belief of seeking health care only when there is a pain.

According to van Dyk (2012: 122), one of the issues discovered about Adherence to Antiretroviral Therapy was that some people used medicines from traditional healers concurrently with ARVs without notifying the health care worker. This shows that belief in traditional herbs is a strong cultural aspect. There are strong ties between traditional healers and their communities (Vasuthevan & Mthembu 2014: 460). The researcher also looked into such cultural practices about health-seeking behaviour since a cure for HIV has not been confirmed. Up till now, only a variety of Antiretroviral drugs have been proved to be effective to control the virus and prevent its spread. According to Evian (2011: 32), treatment with ARVs is effective in reducing the spread of HIV. Even though there are traditional healers, who claim to cure HIV (Audet et al. 2017: 3) and some

community members consult them. There has been no traditional treatment officially declared to be effective for treating HIV nationally in South Africa.

Similarly, Samburu women in Kenya believed in the use of traditional herbs first when ill and also thought that cause of the illness is jealousy (Wanyoike 2011: 177). If people are using traditional herbs, there may be a possibility of spreading the virus since the virus can continue to multiply, and they remain infectious. Similarly, it was found by Walwyn & Maitshotlo (2010: 10) that there is a strong belief towards local traditional healers. In the Eastern Cape, traditional healers had people who were HIV positive (Walwyn & Maitshotlo 2010: 13), but they did not consult medical practitioners. In Bushbuckridge news on 18-January-2013, a traditional healer, Shokane said he treated  $\pm$  5000 people he confirmed that he could treat other illnesses such as Pulmonary Tuberculosis, Diabetes, Asthma, Diarrhoea and “Mafulatsha” (Dibakoane 2013: 01). The same was noticed in Nigeria; some people preferred traditional treatment for HIV (Dibua 2010: 6). Some Tsonga people believed mental illness can be treated traditionally (Hallal, Raxach, Barcellos & Maksud 2015: 168) Some Tsonga people still combined Christian practices and traditional healing (Halala 2012: 386). Similarly, in Swaziland, the Swazi community had late consultations due to consulting traditional healers first, especially older people (Nxumalo 2014: 32.). Again, a similar practice in Venda where almost 80% confirmed that they seek traditional treatment since they have a strong belief in traditional healers and that it is possible to prevent Sexually Transmitted Infection and it can be treated traditionally (Mulaudzi 2005: 323, 324).

The danger is that if people believe that STIs can be treated traditionally, the same thing will be done even if they are HIV infected because HIV is transmitted mainly through unprotected vaginal sexual intercourse (Mogotlane et al. 2014: 347). Even circumcision was preferred to be performed by traditional healers who were sterilizing equipment (van Dyk 2012: 229). It is not known if the sterilization process is done in the same way as in public hospitals. In the era of HIV and AIDS if traditional healers can be educated about all risky practices they can help and become effective agents of change through the authority they have in their respective communities (van Dyk 2012: 229).

#### **2.4.1.2 Witchcraft**

The belief in witchcraft in some African cultural groups still hindered the fight against HIV in African countries. In Malawi, another cultural belief that influenced the spread of HIV was witchcraft. This was followed by visiting a traditional healer. In some instances, family members were identified as the underlying cause of HIV related health problems (O'Brein & Broom 2013: 588). The cause of HIV infection is a virus, not witchcraft (Mogotlane et al. 2014: 362). Almost 69% of South Africans who are HIV infected consult traditional healers and then medical practitioners (Audet et al. 2017: 1). This is because some people do not associate illness with natural cause especially when a traditional healer views the sickness in relation to witchcraft, evil spirit or saying it has to do with ancestors (McClellan 2012: 36). People in Nigeria still had a superstitious belief for illness. It was associated with witchcraft (Dibua 2010: 7). Traditional healers need to work hand in hand with health workers. Individuals and community at large can be able to alter lifestyle factors, community influences, and cultural beliefs (McClellan 2012: 40). Determinants of health such as risky and harmful cultural practices can be modifiable through the power of health care professionals and the health messages (McClellan 2012: 40).

Similarly, in South Africa, illness is attributed to witchcraft as the ultimate cause (van Dyk 2012: 220). According to Fuller (2008: 86), the death of a man is a result of witchcraft. Again Tsonga people believed that witchcraft is there and can result in death (Halala 2012: 181). According to Halala (2012: 181), death was thought to may have been caused by another person. All these beliefs influence the health-seeking behaviour of many Africans. In the HIV and AIDS era, sickness will result in people consulting many traditional doctors, and this result in a delay to commence with Anti-Retroviral treatment. In most Zambian communities, matters about a woman who is pregnant or having to give birth were not shared openly due to fear of being bewitched. It is important to take into consideration the beliefs of witchcraft to structure AIDS prevention programmes, including services such as Prevention of Mother to Child Transmission of HIV (PMTCT) (van Dyk 2012: 221).

#### **2.4.1.3 Ancestral beliefs**

In Africa, some people believe that ancestors form an important and intrinsic part of their daily lives (van Dyk 2012: 217; McClellan 2012: 36). They believe that sickness may be a signal from ancestors that they are angry (McClellan 2012: 36). African cultural practice called “*Ku phahla*” is a ritual belief in ancestral worship which is done to communicate with spirits. It is a type of African religion (Halala 2012: 172). People can do this ritual when there is an illness. According to van Dyk (2012: 217) illness can result due to lack of protection from ancestors and Africans consult traditional healers for diagnosis and a medical Doctor for treatment (van Dyk 2012: 200). These beliefs can lead to the spreading of a virus as people will not know their HIV status.

On the other hand, some people believe that ancestors can cause illness as a form of punishment (van Dyk 2012: 222). It is important that people should be aware that if they experience sickness in the era of HIV, the underlying cause of sickness related to HIV is a virus (Mogotlane et al. 2014: 362) and not any other thing. It is crucial that health education should be given before the disease occurs, detecting HIV early and that those that are infected should prevent the spread (Mogotlane et al. 2014: 362). The fact that illnesses caused by ancestors are said to be less serious and usually not fatal (van Dyk 2012: 218) may result in people delaying consulting early since early symptoms and HIV related conditions during the early stages of HIV are less serious and not fatal.

#### **2.4.2 Aspects Related to Marriage**

This theme focuses on issues related to marriage. The theme has the following sub-themes: Payment of bride price (*lobola*), Witchcraft, and Ancestral beliefs.

##### **2.4.2.1 Payment of bride price (*lobola*)**

Women are expected to make their husbands happy (Nyoni 2008: 86) as “*lobola*” helps African husbands to own bodies. Women are to submit themselves in Zimbabwe, must show submissiveness and must display passiveness and dependency (Nyoni 2008: 88) women must be loyal (Fuller 2008: 61). According to Zimbabwean practice after payment of “*lobola*,” a woman cannot deny sex to her husband. A man has a right to have sex with her. This means that as long as “*lobola*” is paid, a woman is compelled to engage in sex

with her husband as long as he requires it (Nyoni 2008: 128). The value of women seems not to be regarded due to the payment of bride price, and they cannot exercise their sexual rights. Similar to Zimbabwean women, Venda women were expected to be subordinate to their husbands, especially after payment of bride price (Mulaudzi 2005: 334). This means the bride price has negative effects on women.

In the rural communities of Mpumalanga, women experienced a lot of gender inequality in their marriage because of the payment of bride price such that they were constantly reminded about bride price (*lobola*). This led to a situation where men felt that they were entitled to sex anytime. Unfortunately, the suggestion of condom use resulted in violence towards their female sexual partners (Madiba & Ngwenya 2017: 60). It is important to recognize social and cultural issues which influence gender inequalities creating unequal opportunities and risky environments for men and women (Stephenson, Winter & Efotron 2013: 790). In addition to addressing cultural issues, it is also important that issues of gender-based violence against women and girls of being forced into sexual intercourse are addressed (Buzuidenhout 2013: 235; Department of Health 2016: 27). Factors perpetuating the spread of HIV should get the attention it deserves. The violence, which goes hand in hand with the subordinate position of women, leads to an inability to use condoms and vulnerability to HIV infection. Women and girls need to conquer through empowerment to decrease the number of HIV infections all over South Africa (Department of Health 2016: 26).

#### **2.4.2.2. Early marriage in women**

Early marriage is promoted in some cultures. According to Sovran (2013: 5), some women in Sub-Saharan Africa get married at an early age. Women who get married early find themselves to be sexually active at an early age. Similar to the Zulu culture, Samburu women are getting married at an early age, from ten to twelve years. Young women can even be forced to get married to a person who is HIV infected (Wanyoike 2011: 183). Early marriage of young Nigerian girls happened when parents offered a girl child for marriage, and they then start to engage in sex (Ayapo 2009: 28; Aniebue & Aniebue 2009: 54). The vulnerability of women to HIV relates to multiple cultural practices. In Zambia, it was a pride to have an early marriage with some girls being taken for marriage before

puberty. Early marriage was recommended because it was believed menstruation washes away children (Muller & Moyo 2011: 5). One of the goals of the NSP is to prioritize the addressing of social and structural factors that increase the vulnerability of young girls and women to HIV. Early marriage means that a young woman will engage in sexual intercourse early, which suggests that they may be vulnerable to HIV, especially if involved with an older person who has been sexually active before. Young girls in the rural areas of Zambia got married early and could not attend school due to early marriage. Some of them were married to older men, some being second or third wife (Muller & Moyo 2011: 5).

#### **2.4.2.3 Polygamy**

Polygamy has been practiced by African societies (van Dyk 2012: 224). Polygamy refers to “the practice or custom of having more than one wife at the same time (Concise Oxford Dictionary 2011: 1112). Nigerian men practiced polygamy and promiscuity on the other hand. This was acceptable for men to have affairs before marriage (Ayapo 2009: 25). Men’s promiscuity made women vulnerable to HIV and thus causing the spread of HIV (Ayapo 2009: 25). In Maiduguri, polygamy is not a problem but an extramarital relationship (Saddiq, Tolhurst, Lallo & Theobald 2010: 146). Polygamy needs faithfulness. Polygamy will be protective if partners are faithful (van Dyk 2012: 224). It can be dangerous if one wife dies of HIV, the husband will continue to have sex with the others, thus resulting in the spread of HIV to all of them. Polygamy was also practiced at Msinga in the rural area of Kwa Zulu Natal in SA where men can marry two or more wives. This is coupled with the early marriages of girls (Mogotlane et al. 2014: 39). For the Samburu community, polygamy is a sign of good economic status. Polygamy is also practiced in Venda (Mulaudzi 2005: 337) Polygamy was said to be a contributory factor to HIV infection as men engaged themselves in extramarital affairs (Wanyoike 2011: 181). Polygamy in Stoneridge was practiced; even the chief had five wives and four girlfriends. It was stressed that wives must be faithful (Campbell 2010: 1039).

Polygamy was practiced by the Tsonga community. Polygamy for Tsonga cultural group is understood similar to the way the Samburu community practiced it, and it denotes that a man has good financial status (Halala 2012: 174). Traditionalists promote polygamy

(Halala 2012: 176). In the era of HIV, measures should be taken to make awareness regarding the unfaithfulness of partners in a polygamous relationship and the consequences it can have in the community. It was recommended that even though polygamy is practiced according to customary law, it should be done in a way that will not result in detrimental effects on women (Mulaudzi 2005: 335). There must be loyalty, and between husband and all wives, extramarital sex must be discouraged (van Dyk 2012: 224).

### **2.4.3 Gender Issues**

This theme highlights the aspects of gender as one of the major determinants affecting the management of HIV and AIDS. The theme has five sub-themes namely: Socialisation of children, Freedom of men, Patriarchy, Submissiveness of African women and Position and status of African women.

#### ***2.4.3.1 Socialisation of children***

Culture determines practices around upbringing, gender roles, and marriage-related issues. According to the Venda culture, a girl child is under the father when young and under her husband after getting married. Virginity was ensured for girls, but boys were never checked (Mulaudzi 2005: 330). In the Venda culture, men are treated differently from women (Mulaudzi 2005: 323). During her upbringing, a Venda girl child was taught to be submissive (Mulaudzi 2005: 329).

Similarly, Zimbabwean women were taught that they should be devoted, divine pure, modest, and reproductive (Fuller 2008: 83). Ndebele women's roles include to cook and to give birth to children (Fuller 2008: 83). In the Muslim culture, it is believed that the body of a woman belongs to her husband (Fuller 2008: 84). A girl child grows in an environment which says marriage is important for a woman according to the cultural practice in Zimbabwe (Nyoni 2008: 81, 82). When early pregnancy happens in a Zimbabwean woman, it can mean a trap for a male (Nyoni 2008: 128). Unfortunately, in the era of HIV, trapping a man can also result in contracting HIV since pregnancy suggests that one has engaged in unprotected sex. Among the Zulu community similar to Zambian rural communities, early marriage is practiced, education is not important for girls; thus, they

get married at a young age (Mogotlane et al. 2007: 36). In the African culture, there is a general practice of having specific roles for males and females (Dadoo, Ghyoot, Lephoko & Lubbe 1997: 15). It is clear that several communities value marriage even if it would mean early marriage, which can predispose a girl child, it is fine as long as one conforms to this cultural expectation.

#### **2.4.3.2 Freedom of men**

In America, young black men were expected to be dominant in sexual activity, and they were free to be promiscuous and were regarded to be superior when it comes to sexual matters, and they were regarded as the best. This created pressure to prove that they are good at sex such that they were to perform sex at a higher level as they were Black. Abstinence was regarded as the inability to acquire partners (Harper, Tyler, Bruce, Graham & Wade 2016: 468). In the era of HIV, such practices encourage the spread of HIV.

Moreover, some young Black men communicated some messages which were discouraging condom use. They said that condom decrease pleasure; thus, they had more sexual satisfaction without the use of condoms (Harper et al. 2016: 469). These were some of the social elements which influenced risky behaviour when it comes to HIV (Harper et al. 2016: 472). In Africa, Nigerian men were found to have freedom when it comes to sexual matters (Ayapo 2009: 25).

Similarly, Venda males were promiscuous. This practice was not disapproved; women did not have open communication with men when it comes to sexual matters (Mulaudzi 2005: 334; 401). Social norms in Zimbabwe approve promiscuity for men. Men deal with women as sexual objects (Nyoni 2008: 138). Nigerian men can have sexual partners, yet women were not allowed. This showed a spirit of inequality Dibia (2010: 5). Women did not have reproductive health decisions (Nyoni 2008: 77). This showed that women were not valued (Nyoni 2008: 76).

In Malawi, males and females would have multiple partners, but this behaviour was mostly observed in males, and it was acceptable to the community (Peters, Kambewa & Walker 2010: 281). People engaged in sexual intercourse outside marriage (Peters et al. 2010: 287). Similarly, it is acceptable in the Zulu culture for men to have multiple partners. Men



are known for not getting tired when it comes to sex (Mogotlane et al. 2007: 41). Part of socialization of women in Zimbabwe involves lack of say for women (Nyoni 2008: 75), yet they were treated as sex objects (Nyoni 2008: 96). In Zimbabwe, women were expected to make their husbands happy, and “lobola” helps African husbands to own the bodies of their wives (Nyoni 2008: 86). It is important in the era of HIV to recognize cultural practices that trample over the rights of women and children (Banda & Kunkeyani 2015: 45).

Having multiple sexual partners is one of the factors contributing to HIV infection (Evian 2011: 412). In Kenya, some males have more than one partner (Wanyoike 2011: 49). They had multiple partners, concurrently and some European friends at the same time. Unfortunately, it was found that in Nigeria, young people get involved in sex before marriage (Ayapo 2009: 143). The habit of multiple partnerships is also made by women. Samburu women in Kenya who were married had secret lovers called “sindani” (Wanyoike 2011: 186). Some even had seven to ten sexual partners. In Nigeria, men can have sexual partners, yet women are not allowed (Dibua 2010: 5). This shows that there is inequality between men and women in addition women are made vulnerable to HIV due to cultural, economic and biological makeup of their genital organ which can allow infected semen to be deposited into the vagina or inflammation of the genital tract due to Sexually Transmitted Infection or raw area during the menstrual period (Evian 2011: 405, 406). It is important not only to identify cultural practices related to the risk of HIV but to help develop intervention strategies through conducting qualitative studies to have a deeper understanding and look into cultural messages which have potential to influence risky behaviour such as promoting multiple concurrent partnerships of males (Harper et al. 2016: 474). The researcher, in line with the literature, wanted to know any Tsonga cultural issues influencing the sexual behaviour of community members.

#### **2.4.3.3 Patriarchy**

Patriarchy is one of the cultural practices which helps to reinforce the minority status of a woman in most families (Madiba & Ngwenya 2017: 60). The Venda culture also practice patriarchy (Mulaudzi 2005: 335), males are the heads of the family; a woman joins the family of her husband. Similarly, in the Zulu culture, males are heads of the family. Within the community of Msinga, patriarchal families were creating difficulties for women to

initiate preventive measures against HIV (Mogotlane et al. 2007: 42). This was not different from males who had more power in the Venda culture (Mulaudzi 2005: 330; 334; 401). Van Dyk (2012: 59) also states that African women are afraid of their husbands. This fear relates very well with the powers possessed by males in patriarchal families. Similar to the above cultural groups, in the rural areas of Mpumalanga patriarchy was one of the systems entrenched in their cultural practices and it helped to re-enforce women's status of a minority, where they were not allowed to have a say in sexual matters not even to have the opportunity for decision making. What was also noticed in the rural areas of Mpumalanga was that due to the practice of patriarchy, which legitimizes men's domination, and women are then subordinates to their partners. Women were experiencing a whole range of effects of patriarchy and gender inequality, which increase their vulnerability to HIV (Madiba & Ngwenya 2017: 60). In the era of HIV, there is a need for women to have a say in sexual matters as this can affect their health if they can't initiate condom use or take part in the Prevention of Mother to Child Transmission. The NSP identified patriarchal practice as a challenge and recommended that there should be "paradigm shift in the deeply entrenched social, cultural and concepts such as patriarchy that exposes women to risk "of HIV (Department of Health 2016: 5).

#### ***2.4.3.4 Submissiveness of African women***

Some African women become vulnerable to HIV due to a lack of assertiveness. Zimbabwean women cannot voice their opinions (Nyoni 2008: 126). Women were also found to be non-assertive and ignorant (Nyoni 2008: 97). Similarly, in the Venda culture, some women were found to be powerless, and they wanted to be loyal to their partners, they could not suggest the use of condoms (Mulaudzi 2005: 333). Zimbabwean women lacked negotiation skills in relation to safer sex (Nyoni 2008: 68), and they were non-assertive (Nyoni 2008: 129) and could not demand safer sex (Nyoni 2008: 130). Females did not have open communications regarding HIV and condom use (Nyoni 2008: 133) and as such married women contracted HIV. Authority of males in Zimbabwe resulted in women failing to have full control or a say regarding most matters, including sex (Nyoni 2008: 78). Zimbabwean women were expected to be available for their husbands for sex and could not refuse since it is regarded as disrespectful (Nyoni 2008: 84). Similarly, women had a lack of say in the Zulu culture (Mogotlane et al. 2007: 40). Similarly, the

position of Muslim women in Maiduguri in Nigeria made them not to be able to initiate a condom (Saddiq et al. 2010: 149). Otherwise, a woman would be said to be promiscuous.

In Mpumalanga, predominantly Swazi women were expected to honour, obey, and submit to their husbands and the rates of HIV were attributed to the domination of males (Madiba & Ngwenya 2017: 60). Women in several African communities are vulnerable to HIV due to being unassertive and being treated as inferior to their sexual partners. In the Zulu culture suggesting the use of a condom by a woman would mean she learned about it from someone else (Mogotlane et al. 2007: 41). A topic of condom use was a no-go area and a taboo in the Zulu culture (Mogotlane et al. 2007: 42). According to Fuller (2008: 328), African girls should not question males as per African custom. Girls would be expected to be “obedient” or humble or show respect to people. In the Venda culture, women were expected to respect their husbands; they were not to raise opinion for family matters and sexual issues (Mulaudzi 2005: 330). This suggests that freedom of speech is not exercised in matters affecting girls and women, including initiating use of a condom.

Swazi women ‘s cultural belief in the rural areas of Mpumalanga was that men are entitled to sex yet trying to discuss condom use openly was regarded as questioning the authority of their sexual partners (Madiba & Ngwenya 2017: 60). Similarly, Venda women were expected to be submissive (Mulaudzi 2005: 328). They were expected to engage in sexual intercourse at all times (Mulaudzi 2005: 329). Samburu women in Kenya were subordinate to men (Wanyoike 2011: 72) similarly to Venda women are subordinate to men (Mulaudzi 2005: 333). This is influenced by the fact that “*lobola*” is paid bride price (Mulaudzi 2005: 334) women could not say no to their husbands even if they are aware that condoms are not used (Vasuthuven & Mthembu 2014: 175). Condoms could only be negotiated by males (Vasuthuven & Mthembu 2013: 251). After payment of “*lobola*” the subordinate position of women (Mulaudzi 2005: 324) resulted in Venda women becoming compelled to give consent always for sexual intercourse with husband. Submissiveness was something that was taught about for the Venda girls (Mulaudzi 2005: 328). This concurs with Madiba & Ngwenya (2017: 59) who said some women could not use condoms because of male dominance; men did not pay *lobola* to use plastic. Until such time that the full human rights of women and girls are exercised it will be difficult to fight

HIV with the South African situation of disproportion in HIV infection as girls and women had high rate of HIV for those in their early twenties having four-fold burden compared to males of their age (Department of Health 2016: 7).

#### ***2.4.3.5 Position and status of African women***

It is not only cultural practices that affect people's health, even the socio-economic factors and political circumstances in which individuals find themselves can affect the health of people (McClellan 2012: 25; Evian 2011: 32). Position of a person in a particular society or community plays a role in affecting one's health (VasutheVan & Mthembu 2014: 2). According to Madiba and Ngwenya (2017: 60), the status of a woman is low; it is that of being subordinate or minor or inferior or even powerless. This is in contrast with African males who are in authority Nyoni (2008: 78) or the power they have to be in control Afoloyan (2004: 203), having rights as a husband over the wife (Afoloyan 2004: 183). Zulu men are in authority Mogotlane et al. (2007: 39) and their position as head of families in patriarchal marriage (Mulaudzi 2005: 335). Position of women and the position of men can put them at risk of contracting HIV. Men usually practice multiple partnerships or have sexual partners even when they are married on the other hand women have less control in negotiating safe sexual practices such as rights to initiate condoms (Evian 2011: 407). There is a need to transform harmful cultural practices and modify them within the era of HIV.

Women in Maiduguri do not have autonomy. Similarly, the authority of males in Zimbabwe makes women be at an inferior position (Nyoni 2008: 98). In Malawi, in Zomba village, women have a low status. Women are regarded as minor and do not have equal status as men (Nyoni 2008: 89). Fuller (2008: 65) states that the role of women is to work more than men, and women are regarded as being inferior to men. Again, women were found to be of low socioeconomic standard (Dibua 2010: 10). In the Venda culture, men have higher status than women. Some women are unemployed; hence, they are dependent and have no say as they want to secure their marriages (Mulaudzi 2005: 334). Women were also of low social status in Kwa Zulu Natal (Vethe 2011: 166). African women were undermined (Campbell 2010: 1642). Zulu men can marry second wives without permission Mogotlane et al. (2007: 34), and they are dependent on their husbands. Men

are heads of family in the Zulu culture. Samburu men in Kenya were in authority over women. Women cannot decide to use a condom even if a man is infected (Wanyoike 2011: 171). Authority, dependency, inferior status has a negative influence with regard to deciding on safe sexual practice. According to van Dyk (2012: 53), South African women cannot exercise sexual rights. The fight against HIV needs empowerment and emancipation of women from all risky practices entrenched in their culture through involving them in HIV prevention strategies that are culturally relevant.

#### **2.4.4 Aspect related to Procreation and Childbearing**

This theme focuses on issues of procreation and childbearing. This theme is composed of four themes, namely: Procreation, Infertility management, Breastfeeding practices and Traditional birth attendants and home delivery.

##### **2.4.4.1 Procreation**

Children are highly valued by both men and women in most African societies, such that in most African cultures, people get married to have children. In Zambia, the status of a woman becomes better when she has children. Motherhood helps a woman to achieve full adulthood (Muller & Moyo 2011: 3). According to Van Dyk (2012: 224), children are important for generations to come and for performing the daily chores of their families. Childbearing in the era of HIV can be risky since there is a lack of condom use for pregnancy to take place. This suggests that for some cultural groups women can take risks of engaging in unprotected sex for the sake of becoming pregnant even if it would lead to contracting HIV, for them as long as one can bear a child.

Procreation or giving birth is important in the Zulu culture, and that is why *lobola* is paid (Mogotlane et al. 2007: 40). A woman is expected to give birth even when her husband has died. She is inherited by her husband's brother (Mogotlane et al. 2007: 40). This concurs with van Dyk (2012: 224) as it was found that childbearing is very important in African society. Similarly, childbearing was found to be important in Zimbabwe in the Ethnic group such as Kokere, Ndebele, Shona, Ndou. As such fertility is highly valued (Nyoni 2008: 81). Fuller (2008: 87) states that the priority role for a woman is that of being reproductive. Some cultures encourage woman to give birth. Unmarried women were to

be procreative to give birth to a male child who will be the successor in the family (Dibua 2010: 6). It is a favourable practice in Nigeria. Pregnancy and childbearing can have serious consequences, including contracting HIV as one engages in unprotected sex. Other cultural practices in the Luo community include intention to have a baby by wife (widow) inheritors with a wife who is inherited leading to the non-use of condoms or use of condoms at the beginning of a relationship but later using condoms inconsistently (Perry, Oluoch, Argot, Taylor, Onyango, Ouma, Otieno, Wong & Corneli 2014: 8).

#### ***2.4.4.2 Infertility management***

Infertility is a serious problem, especially in African cultural groups where children are highly valued (van Dyk 2012: 224; Muller & Moyo 2011: 3). In the case of a man who cannot make his wife pregnant even after being treated with herbs and the woman cannot conceive the family would organize a man who “would sleep with her until she conceives”. This matter is treated as highly secretive as possible between all parties concerned (Muller & Moyo 2011: 3). This cultural practice is highly risky as there is a possibility of contracting HIV in the process of trying to fall pregnant as condoms are not supposed to be used. Infertility can predispose women to HIV if managed traditionally. Realizing the dangers associated with infertility in Malawi, a man who had to help a woman to fall pregnant had to undergo HIV test sometimes. Communities who managed to come up with preventive measures have taken the lead to strategize preventive measures

#### ***2.4.4.3 Breastfeeding practices***

In other countries such as Zimbabwe, some cultural groups have traditional practices which have the potential to transmit HIV to children born in rural areas. The Chiota community had a belief in treatment of the open fontanel which was risky as it involved a procedure of rubbing the baby’s palate with coarse salt until there was bleeding then the mother breastfeeds the baby immediately and it is regarded as a treatment for fontanel. Breast milk of an HIV positive woman can infect a baby. Mothers in law would compel breastfeeding mothers to do this procedure. Alternatively, a baby would have to suck his father’s penis. (Nyathi-Jokomo, January, Rapurangada & Chitsike 2016: 54) Unfortunately, a baby may be exposed to suck semen that is HIV infected.

In contrast to Chiota community, another practice of the Venda community encourages abstinence post-abortion or after delivery (Mulaudzi 2005: 336). This practice was applied to the woman and was not applied to males. This suggests that men have the latitude to behave as they want when their wives are observing the period of sexual abstinence as expected from a breastfeeding woman culturally. Unfortunately, if the father can engage in unprotected sex with an HIV positive woman, the breastfeeding mother can contract HIV, thus resulting in Mother to Child Transmission. It is possible to have a horizontal transmission of HIV through breast milk (Mogotlane et al. 2014: 347).

According to Coovadia and Wittenberg (2010: 210), it has been found that if there is no intervention some infants born of HIV infected mother acquire the infection through breastfeeding. "Transmission of HIV can occur at any time while a child is breastfeeding" Increased risk is associated with longer duration of breastfeeding and if the disease is severe and the baby has oral infection or mother's breast is not healthy such as fissured nipples. A baby can be safe if exclusively breastfed for six months and breastfeeding beyond six months can increase the risk of HIV infection (Evian 2011: 321) The availability of Prevention of Mother to Child Transmission program can help to prevent the spread of HIV (Evian 2011: 310). Breastfeeding mothers must practice safe sex.

#### ***2.4.4.4 Traditional birth attendants and home delivery***

In a study conducted in Swaziland, Thwala, Jones, and Holroyd (2012: 9) found that Swazi women preferred to give birth at home as a cultural expectation and some used traditional treatment to hasten labour. This practice prevents midwives in hospital from implementing a programme called Prevention of Mother to Child Transmission (PMTCT). According to Sustainable Development Goals number (3) which focuses on health and wellbeing to ensure healthy lives and promote wellbeing for all at all ages and goal number (5) focusing on Gender inequality so as to achieve gender equality and empower all women and girls, women should have access to health care services including Mother and Child health care services. Some Samburu women preferred to deliver at home (Wanyoike 2011: 164, 165). This can predispose babies to HIV since the health status of the mother is not known, and the baby cannot get prophylaxis when delivered at home.

This cultural practice of home delivery of any African woman can promote the spread of HIV as it can hinder giving HIV positive mothers, and infants' medication to prevent the transmission of the virus. According to Evian (2011: 26), a mother who is infected with HIV can pass on the virus to the unborn baby. The risk of mother to child transmission can be reduced by giving of ARVs and avoiding unnecessary procedures such as rupture of membranes or trauma to the foetus and prolonged labour. Unfortunately, the transmission of HIV to the baby can happen during breastfeeding (Evian 2011: 27). It is important for women to be empowered regarding such dangerous practices of giving birth at home

#### **2.4.5 Rituals**

This theme focuses on rituals which are performed which affect HIV and AIDS management. It has three themes, namely: Initiation, Widow cleansing and Widow Inheritance (Wife inheritance).

##### **2.4.5.1 Initiation**

Initiation is one of the cultural practices in Malawi, matters about initiations are not discussed openly, but some of the things said to be happening at initiation schools was to teach girls how men and women engage in sex. These acts included risky practices such as encouraging girls from initiation schools to engage in sex immediately after initiation, which was regarded as cleansing of dust. This practice was risky as some girls would be encouraged not to refuse sex with anyone, such as older men who were called hyena. Engaging in sex is regarded as a transition from childhood to adulthood (Skinner, Underwood, Schwandt & Maqombo 2013: 298). Realizing the risks and vulnerability of girls following initiation, it was recommended that there was a need to modify or stop those cultural practices and educate initiators and parents about HIV and pregnancy and the possibility of teaching at the initiation (Skinner et al. 2013: 299). Also, it was recommended that initiation rites should be understood about how sexual behaviour can be influenced and thus causing vulnerability to HIV, such as engaging in sexual intercourse immediately after initiation. Any contradicting message which is based on culture needs to be addressed to disseminate HIV preventive messages (Skinner et al. 2013: 300).



Similar to Malawi, initiation is one of the African cultural practices; Samburu women were undergoing female genital mutilation. This was a sign of moving from childhood to adulthood (Wanyoike 2011: 197). After initiation school, girls and boys should have sex (Banda & Kunkeyani 2015: 42). Realizing the risks and vulnerability of girls following initiation, there was a need in Thyolo district of Malawi to modify or stop risky cultural practices and educate initiators and parents about HIV and pregnancy and the possibility of teaching initiates (Skinner et al. 2013: 299). In the Venda cultural group initiation schools for girls taught about which practices predisposed them to sexual abuse and submissiveness but had to fear sex before marriage (Mulaudzi 2005: 328). In contrast, among the Tsonga community, boys were prepared for manhood, and girls were prepared for marriage and carrying for future husband (Halala 2012: 177). Even if initiation was disapproved by missionaries, Vatsonga felt strongly about this practice (Halala 2012: 180).

Another common initiation is male circumcision. Circumcision is a traditional practice that is done in South Africa by different cultural groups such as the Xhosa, Venda, Ndebele, Sotho, and Zulu cultural groups. Even though some people prefer to do it in the hospital, many prefer the traditional surgeon to perform it (Mogotlane et al 2014: 40). According to van Dyk (2012: 231), health workers should find ways to handle harmful rituals such as circumcision so that rituals can be done safely, including the use of instruments. People should know that circumcision is not a license to engage in sex, safety measures through the use of condoms must be used correctly and consistently.

#### ***2.4.5.2 Widow cleansing rituals***

Some Africans believe in cleansing rituals after funeral (Muller & Moyo 2011: 770) The procedure for sexual cleansing involves engaging in sexual intercourse without using a condom, if a condom is used cleansing will not take place if a condom is used a custom has been broken (Perry et al. 2014: 6). In Zambia, people observed sexual abstinence when someone has died. This is followed by a ritual of sexual cleansing. In the case of a widow or unmarried woman, a man is hired from the village to sleep with her to dispel evil spirits. This ritual contributed to a lot of deaths in sub-Saharan Africa as sexual cleansers were spreading HIV during the process of working as a cleanser. Due to the detrimental

effects of sexual cleansing ritual, people are now using herbs or cutting hair or conducting prayers (Sovran 2013: 7). In the eastern region of Malawi harmful cultural practices such as sexual cleansing after the mourning period was remodelled due to the potential risk of HIV and AIDS. Strong medicines or traditional herbs could be used or the use of condoms instead of cleansing sexually (Banda & Kunkeyani 2015: 43).

Similarly, in the Venda people, the practice of conducting a cleansing ritual for a woman who lost her husband was done. A widow was expected to undergo sexual cleansing ritual before she could have sexual contact with a man (Mulaudzi 2005: 332). Unfortunately, the risk of cleansing ritual is worsened by situations where a married man confirmed that he did sexual rites for multiple widows and he was being hired for some widows and he did it for one night to three different women (Perry et al. 2014: 6). This confirms that widow cleansing can be a vehicle to spread HIV to several women within a short time. Other cultural groups such as the Luo have become aware of the dangers of sexual cleansing and have recommended the use of HIV preventive products for widows as it is believed that sex is essential for sperm and vaginal fluid to be mixed (Perry et al. 2014: 10). It is high time that studies should be done, and recommendations made in line with addressing harmful cultural practices, including cleansing rituals and widow inheritance.

#### **2.4.6.3 Widow Inheritance (*Wife inheritance*)**

Widow inheritance is one of the common risky cultural practices that can promote the spread of HIV in African communities (Sovran 2013: 5; Banda & Kunkeyani 2015: 43; Mogotlane et al. 2007: 40; Perry et al. 2014: 2; Sovran 2013: 5). Countries such as Malawi had a cultural practice of wife inheritance. Due to its negative consequences in the era of HIV, the widow and inheritor had to undergo HIV testing. Alternatively, if the widow remains at her husband's family, then the husband who inherited her would only support her with material things and not engage in sexual intercourse with her (Banda & Kunkeyani 2015: 43). Similar to this cultural practice, in Malawi, widow inheritance is a cultural practice among the Venda community. A widow can be married by someone in the family (Mulaudzi 2005: 331). Again, wife inheritance in the Zulu culture in South Africa is practiced. In case of death of husband, the widow remains in the family. According to

the Zulu culture, a brother or uncle of the deceased inherits the widow (Mogotlane et al. 2007: 40). In the era of HIV, it is risky to engage in sexual intercourse with a person who lost a partner if the cause of death is not known, and HIV status is unknown.

Also, wife inheritance in Zimbabwe is practiced where marriage is organized without the consent of the woman (Nyoni 2008: 147). Again, another cultural group such as the Swazi community, women inheritance known as “kungena” is practiced. According to Wanyoike (2011: 194), if a man dies, a woman is supposed to be married. She should be blessed with a husband who is a relative of her husband; a woman is allowed to engage in sexual intercourse while waiting for the process (Wanyoike 2011: 194). In the Zulu culture, the brother of a deceased husband is made to be responsible for the conjugal rights of a widow. At Msinga conjugal rights are very important. This is known as “ukungena” (Mogotlane et al. 2007: 40). This practice is a concern during cleansing rituals and wife inheritance those practicing this can be at risk of HIV infection (Sovran 2013: 7). Unfortunately, the cause of death of the widow’s husband may be HIV infection (van Dyk 2012: 231). Cleansing and inheriting a widow may have serious consequences to the inheritor, his wife/ wives, including unborn children through Mother to Child Transmission.

#### **2.4.6 Sex and Sexuality**

This theme focuses on sex and sexuality behaviours. It is composed of the following sub-themes: Lack of discussion about sexuality issues, Taboos related to sexual information, Dry sex and Multiple Concurrent partnerships.

##### ***2.4.6.1 Lack of discussion about sexuality issues***

Sexuality matters are not usually discussed in African culture. In Tanzania, many parents were found not to be open with their children, and some gave incomplete messages such as warning them not to be involved with men without stating the reason why (Fehringer, Babalola, Kennedy, Kajula, Mbwambo & Kerrigan 2013: 209). Parents failed to speak to their children about multiple partners as they were doing that. Some parents were afraid to talk to their children about sexuality as they thought children would then be encouraged to have sex. Unfortunately, some parents encouraged their daughters to have multiple partners quietly for extra cash or food and other material resources (Fehringer et al. 2013:

210). Similarly according to the Venda culture it was taboo to speak about sex education to one's own children. It is a topic which must not be discussed (Mulaudzi 2005: 328). Again in South Africa, Vetthe (2011: 151) found that some parents and teachers were not keen to speak about HIV to children. Due to cultural related factors, there was a lack of utilization of teaching sessions of Life Orientation by teachers as they regarded sexual education as immoral (Vethe 2011: 153).

#### ***2.4.6.2 Taboos related to sexual information***

Taboos are one of the common aspects of African culture. According to DePalma and Francis (2014: 551), it was regarded as taboo to discuss matters relating to sex in Kwa Zulu Natal (Vethe 2011: 178). It was taboo to discuss condoms in Kwa Zulu Natal (Mogotlane et al. 2007: 41). Guidance on sexuality issues is a topic which is not getting attention in the era of HIV as this is attributed to taboos. It is also considered as a taboo to divulge information for any man who did not go to the initiation school and especially women. It was also found that Life Orientation teachers confirmed that African parents do not talk about sex openly and talking about sex was taboo and talking about sexuality issues is something associated with disrespect in the African culture (De Palma & Francis 2014: 554). Talking about sexuality to your child is taboo in the Venda culture (Mulaudzi 2005: 328). It was also regarded as taboo if one engages in sexual activity during menopause in the Venda culture (Mulaudzi 2005: 332). In Kwa-Zulu Natal, it was taboo to discuss the use of condoms for sexual intercourse. It was thus difficult for Zulu women to insist on condom use (Mogotlane et al. 2007: 42).

In addition, it was considered a taboo for a man to have one partner (Mogotlane et al. 2007: 40). This is a clear indication that multiple partnership is promoted by such things. The application of some taboos in different situations hinders the fight against the spread of HIV. In the case of young girls and boys, it is important for them to be taught about the dangers of unprotected sex, failing to empower young people can have devastating results as they can contract HIV. It is better to prevent the virus than to treat it. Taboos are part of cultural practices of different cultural groups. Banda and Kunkeyani (2015: 45) recommend that in order to fight HIV it is important for communities to consider

modification and remodeling of harmful cultural practices that hinder the fight against HIV and AIDS thus help people to see the reality in the era of HIV.

#### **2.4.6.3 *Dry sex***

Other risky practices towards contracting HIV was that African men prefer dry sex in countries such as Malawi, Cameroon, Ghana, Kenya, Zaire, Zambia, and Zimbabwe. This goes with the tendency of not using condoms (Fuller 2008: 74) on the other hand; gender inequality creates an environment favourable for gender violence (Fuller 2008: 79). Women in Nigeria have to undergo female genital mutilation as a way of preventing libido. Other risky practices for Samburu women were involved in early marriage, multiple partners, polygamy, and secret lovers, according to Fuller (2008: 72). African women perform things such as sexual cleansing, polygamy, and dry sex. Similar practices were found by Wanyoike (2011: 107) such as polygamy, wife inheritance, and multiple partners. Van Dyk (2012: 231) also found that risk practices to HIV and AIDS include multiple sexual partners, cleansing rituals, wife inheritance, and dry sex. Unfortunately, a woman can sustain lacerations or bruises if dry sex is promoted, and this will make them highly vulnerable to HIV infection. Inflammation of the genital wall can lead to increased chances of HIV infection, and the healthy vaginal tract is less likely to acquire HIV (Evian 2011: 28). In Zimbabwe dryness of vagina is promoted to please the husband. Tsonga community practices ritual cleansing after the funeral (Halala 2015: 171). Some widows resorted to sex for money (Dibua 2010: 12). There is a belief that sexual intercourse using a condom deprives a foetus of proper development. Semen is believed to help to improve the beauty, physical, mental development, and future fertilization of a woman. Medically, engaging in sex during pregnancy without a condom can expose a woman to contract HIV as pregnancy lowers the resistance of a woman.

#### **2.4.6.4 *Concurrent multiple partnerships***

The identification of men and their behaviour is directly influenced by their culture. Behaviour such as that of constantly changing sexual partners is based on cultural influence (Sovran 2013: 9). The practice of multiple concurrent partners is common in men (Madiba & Ngwenya 2017: 57; Bezuidenhout 2013: 237; Ombere, Nyambedha & Bukachi 2015: 1151). In researching about gender, culture, and changing attitudes in

Zimbabwe practices were related to multiple partners. Husbands were having several girlfriends because men want to control women and dominate in a relationship (O'Brein & Broom 2013: 592). One man confirmed that he engaged in casual sex because of separation from family due to work-related issues. Some women were sure that infection was contracted from husbands as they had many girlfriends while they got married as virgins. Some men had a tendency to one-night marriage worsened by creating a small house for promoting a temporary or permanent relationship (O'Brein & Broom 2013: 591). It is a fact that when men engage in multiple partnerships without practicing protective sex, women will continue to be vulnerable to HIV infection. A similar practice was reported in South Africa where men are practicing lifetime concurrent partnership with more than two women and there are men who say "extra partner sex is okay" yet they know the risks of HIV when a person is having more than one partner (Kenyon, Osbak, & Boyze 2015: 881). Boys in Sub-Saharan Africa are taught that real men are knowledgeable about sex; they take alcohol and use drugs frequently (Sovran 2013: 9). These risky behaviours result in women's vulnerability and the potential to spread HIV.

Cultural practices were said to play a major role in the high prevalence of HIV in South Africa. Some people even said, "it is fine to have sex with others as long as your main partner does not know or find out." It was also stated that it was a pride for men to have sex with a lot of women, and such men are regarded as real men and called *Ingakara*. Cheating was reported to be happening everywhere. Some have the tendency of having an extra partner because that can help in case a person can break up with a partner. Unfortunately, people even engage in sex with someone besides their partners because they felt so good (Kenyon et al. 2015: 880). In addition, concurrency was reported in most South African black men as something related to their norms and the fact that some women confirmed that it was acceptable for men to have more than one partner (Kenyon et al. 2015: 884). The Zulu culture approves the practice of men having several sexual partners known as "Isoka" (Mogotlane et al. 2007: 41). In the Venda, culture, men were promiscuous and tolerated culturally even in polygamy, they still had extramarital affairs, thus making women vulnerable to HIV (Mulaudzi 2005: 331). There is a need to identify norms perpetuating the spread of HIV and structure health messages that will emancipate

women from these predisposing risky cultural practices and to educate males on behaviour change towards healthy living.

## **2.5 IDENTIFIED GAP IN LITERATURE**

African culture has several HIV risky cultural practices. Most African countries such as Tanzania, Zimbabwe, Swaziland Malawi, Kenya have specific cultural practices which have the potential to spread HIV in the different cultural groups. Scientific studies have been conducted to identify those harmful practices and recommendations were made to address such risky cultural practices after realizing that “prevention strategies have failed in most of Africa” (Buzuidenhout 2013: 241; Vasuthevan & Mthembu 2014: 138; Van Dyk 2012: 217). “Risk behaviour or practices should be the focus of health education”, and everyone should be involved in fighting HIV and AIDS pandemic (Mogotlane et al. 2014: 362). It is important to gain in-depth knowledge about diverse cultural groups to be culturally aware of a specific culture and be relevant to a cultural context (Mogotlane 2014: 20). The beliefs and practices of Africans cannot be ignored but needs to be incorporated in the HIV and AIDS preventive programmes (van Dyk 2012: 217).

According to van Dyk (2012: 231), it is important to take into account local customs, and traditional cultural beliefs since providing general health talks may be ineffective. Strategies such as ABC may have failed dismally since it was a Western model applied as AIDS prevention programmes in Africa (van Dyk 2012: 217). There is an urgent need for inputs from traditional African context plan and incorporate AIDS prevention programmes (van Dyk 2007: 411) to design more effective intervention strategies in line with how people understand health, sickness, and sexuality from their historical, cultural world view. According to Tjale and de Villiers (2004: 265), “health care professionals will only be able to render culture-congruent care if they have a sound understanding of the cultural issues influencing health, illness, and care,” this can only be achieved following conducting research. Regardless of these recommendations and evidence that culture has a significant role to play in the spread and management of HIV, most of the intervention is silent about addressing cultural practice. The intervention utilised are usually Eurocentric, focusing mostly on abstinence, being faithful, condomising, and offering antiretroviral treatment. This study tried to address these gaps.

## **2.6 CONCLUSION**

The chapter has highlighted the literature reviewed in relation to cultural practices and beliefs which may have an impact on the prevention and management of HIV and AIDS. The issues such as witchcraft, traditional healers, rituals, lobola, the status of women in society, breastfeeding and child-rearing were raised as some of those practices. The gaps were highlighted in the literature. The next chapter will focus on the research methodology.



## **CHAPTER 3: RESEARCH METHODOLOGY AND DESIGN**

### **3.1 INTRODUCTION**

The previous chapter presented the literature review process, themes that emerged from the appraisal of relevant literature, and the gaps in the literature. This chapter discusses the research methodology. Methodology refers to the “rules and procedures that specify how the researcher must study or investigate “what needs to be known (Botma, Greef, Mulaudzi & Wright 2015: 41) and conceptualizes it in a specific way (Creswell & Poth 2018: 325). It is the philosophical stance or world view that underlies and informs a style of research. The first section (from 3.2 to 3.6) of this chapter describes research approach, research design, research methods, trustworthiness, sample and sampling technique, data collection format, pretesting of the interview guide, data analysis, ethical consideration and measures to ensure trustworthiness for the first phase of the study, which was situational analysis. The second section (from 3.7) focused on Phase two of the study, which is model development process.

### **3.2. RESEARCH APPROACH**

Qualitative research is defined as a “systematic, interactive, subjective approach used to describe experiences and give them meaning” (Grove, Burns & Gray 2013: 705).” It refers to the investigation of phenomena, typically in an in-depth and holistic fashion through the collection of rich narrative materials using a flexible research design” (Polit & Beck 2008: 763). It involves a description or exploration of a phenomenon (Botma et al. 2015: 182; Grove et al. 2013: 704). It also refers to research “interested in analysing the subjective meaning or the social production of issues, events, or practices by collecting non-standardized data and analysing texts and images rather than numbers and statistics” (Flick 2014: 542). One of the purposes of qualitative research is to explore the phenomena of interest. Thus, the exploratory type of studies are relevant (Leedey & Ormrod 2013: 95). Advantages of qualitative research include the following:

- Thorough description of a situation and understand it (de Vos 2011: 65).

- It is more holistic as it usually focuses on conducting interviews for data collection using a participant's language (de Vos 2011: 66).
- Interviews are conducted to people who are most knowledgeable about the culture, or the topic and they are key informants (Brink et al. 2018: 107)
- According to Grove, Burns and Gray (2013: 290), qualitative research is flexible than quantitative research.

The qualitative research methodology is known for being used in a study where there is not much known about that phenomenon (Brink et al. 2018: 103). As there is limited scientific documentation about cultural practices and beliefs of Tsonga people in relation to how it influences the management of HIV and AIDS, a qualitative approach was the most relevant. Through the use of qualitative approach, the researcher also identified the relevant qualitative research design for studying cultural practices, beliefs, and behaviour.

### **3.3 RESEARCH DESIGN**

Research design is defined as a blueprint of how one intends to conduct research (Grove, Burns & Gray 2013: 692; Grove, Gray & Burns 2015: 510). It is the overall plan for addressing a research question, including specification for enhancing the study's integrity (Polit & Beck 2017: 765). The researcher used ethnographic design, which looked at the role of culture that influences issues of ways of life of a particular culture (Brink et al. 2018: 107). Ethnography aims to reveal detailed and careful descriptions of a specific field which is being investigated (Flick 2014: 42). Ethnography is a qualitative research design which focuses on describing cultural behaviour (Grove, Gray & Burns 2015: 502; Creswell & Poth 2018: 118). Ethnography as a qualitative research design "attempts to understand the phenomenon in its entirety, rather than focusing on specific concepts about social and cultural world" (Brink et al. 2018: 108; Creswell & Poth 2018: 90; Tjale & de Villiers 2004: 250) This was allowing a focus on characteristics or qualities and exploring complex human situations. Ethnographic research provides the researcher with an opportunity to study a specific culture's behaviour and values and to understand cultural complexities (Grove et al. 2015: 503; Leedy & Ormrod 2013: 143). The triangulating of the findings from the ethnographic interviews (core component) and the content analysis

(supplementary component), allows for meaningful convergence (Creswell & Poth 2018: 328; Polit & Beck 2008: 768), corroboration and complementarity of findings and resultant analysis (Leedy & Ormrod 2013:162). This study focused on the Tsonga cultural group who share a common culture (Leedy & Ormrod 2013:142). Researching a culture involves obtaining detailed information about the daily living of people and cultural practices as narrated through lengthy conversations by members of the specific cultural group (Leedy & Ormrod 2013:143).

One of the designs of qualitative research is ethnography that deals with “culture and customs” of specific groups of people. Ethnographic study methods are ways of studying a variety of communities. It focuses on the social and cultural world for a particular group. It is through this design that the researcher becomes empowered to study about the cultural group as “emic” learning from the participants as the owners of a clearly defined group (Brink et al. 2018: 106). The purpose of ethnographic research is to understand the parts of the world according to the experience and the understanding of the daily lives of those people investigated (Crang & Cook 2007: 1). An ethnographic study design enabled the researcher to explore and describe the perspectives, understanding, views, and meaning of Tsonga cultural practices and beliefs in relation to HIV and AIDS management. Research design assists in identifying relevant research methods.

### **3.4 RESEARCH METHODS**

Research methods are the techniques used to structure a study and to gather and analyse information in a systematic fashion (Polit & Beck 2017: 743). This section covers the setting, population, sampling, data collection, and data analysis utilised in this ethnographic study.

#### **3.4.1 Setting**

The study setting refers to the physical location and the conditions in which data collection will take place in a study (Polit & Beck 2017: 744). In a qualitative study, data is usually collected in a natural setting where the participants reside or where the phenomenon to be observed is happening (Polit & Beck 2017: 464). The study was conducted in Bushbuckridge, which is situated under Ehlanzeni district in Mpumalanga province of

South Africa (See Figure 3.1 showing the location of Mpumalanga province in relation to other provinces in South Africa).

## Provinces of South Africa



Figure 3.1 Map of the provinces of South Africa indicating where Mpumalanga province is (Copied from; <https://www.sataxguide.co.za/south-africa-political-map/>)

Bushbuckridge is one of the largest municipalities in the Mpumalanga province (See Figure 3.2 which indicates Mpumalanga province and its municipalities and the location in relation to others).

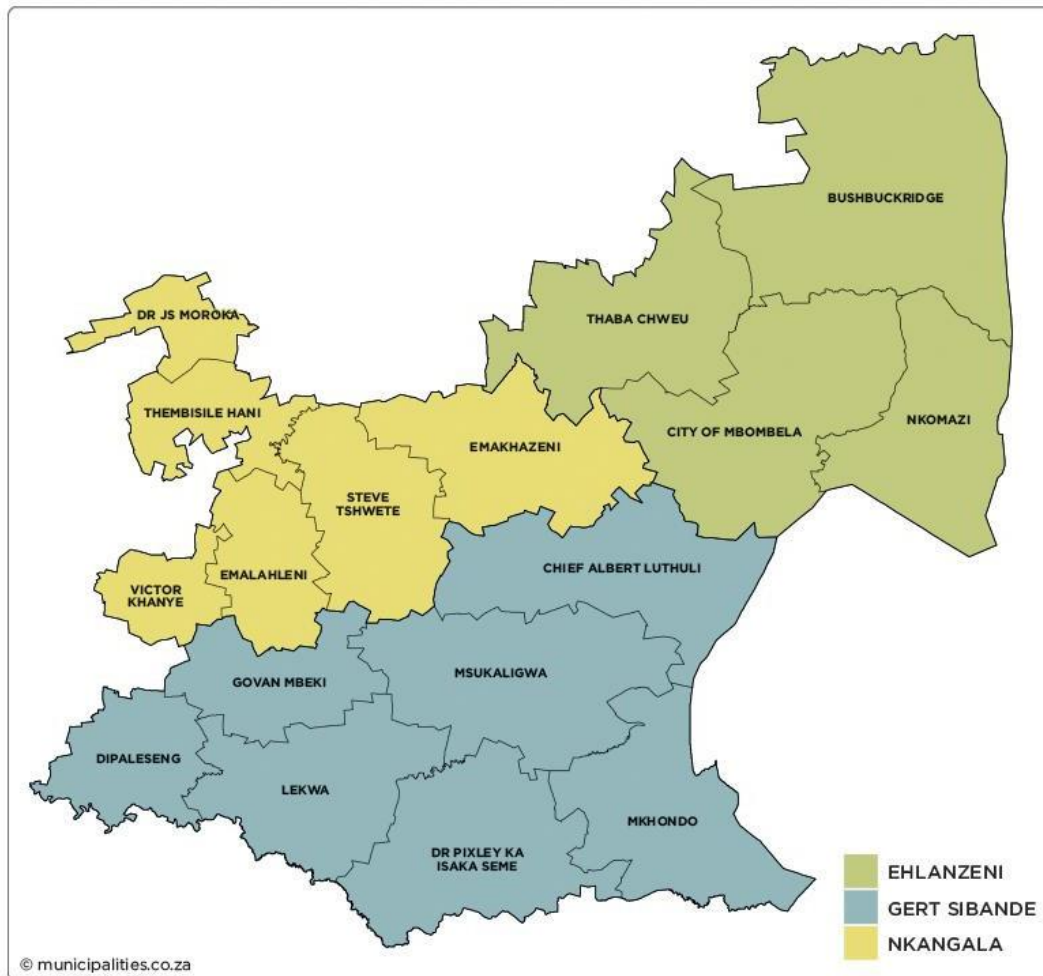


Figure 3.2 Map of Mpumalanga Province. (Copied from <https://municipalities.co.za/provinces/view/6/mpumalanga>)

Bushbuckridge is close to the border of Limpopo and the Kruger National Park. It has a total of 140 villages and locations. The population of Bushbuckridge was 541 248 in 2011 census and 546 216 in 2016 public survey (Wazimap 2016: 1). Public health care services are rendered under Bushbuckridge sub-district. This sub-district has three hospitals, five mobile health services and thirty-eight (38) fully functional Primary Health Care (PHC) facilities providing free health care services daily including services for HIV and AIDS such as health education, counselling for HIV testing, provision of condoms, ARVs and management of HIV related conditions. According to the Integrated Development Plan

(IDP) (2016: 1) of Bushbuckridge municipality situation analysis, HIV is one of the challenges in this area. There is a need to deal with this challenge and to involve all sectors. The HIV infection rate was almost 29%. Economically active men and women between the ages of 14 - 40 years are affected by HIV and AIDS.

### **3.4.2 Research Population**

Population refers to the entire group of persons or objects that is of interest to the researcher (Brink et al. 2018:116). According to Grove et al. (2013: 703), population refers to all elements or subjects that meet sample criteria for inclusion in a study. The population of the study was Tsonga adult community of Bushbuckridge. These people occupy most of the area, which was called Gazankulu during the Homeland system of South Africa. Some of the members of this cultural group were part of the people who broke away from Soshangaan in Mozambique and moved to Transvaal which is part of currently South Africa (Mathebula 2013: 7). They occupy any village under Bushbuckridge municipality. The targeted population was adults aged eighteen years and above.

### **3.4.3 Sampling and Sample Size**

The sample is explained as a part or fraction of a whole or a sub-set of the population that is used for inclusion in the study (Brink et al. 2018: 117). It can also be specific elements that can be used for a study (de Vos 2011: 223). Leedy and Ormond (2012:162) define a sample as that which is consisting of specific entities that are selected by the researcher for analysis. Sampling is defined as a process of selecting groups of people, events, behaviours, or other elements with which to conduct a study (Grove, Burns & Gray 2013: 708). It is the process of selecting the sample from a population to obtain information regarding a phenomenon in a way that represents the study population (Brink et al. 2018: 115). The researcher used non-probability purposive sampling. Purposive sampling is defined as a sampling approach whereby the researcher chooses participants based on specific characteristics, the knowledge or lived experience regarding the phenomenon that is being studied (Botma et al. 2015: 201; Brink et al. 2018: 126). The advantage of purposive sampling is that participants who are knowledgeable about a phenomenon are selected (Grove et al. 2015: 509; Brink et al. 2018: 141). The sample

size in an ethnographic study is based on the researcher's informational needs. Grove, Burns and Gray (2013: 698) emphasise that the ethnographic study does not require a lot of people but "key informants" who are highly knowledgeable about the culture. The sample comprised of women and men from Bushbuckridge municipality. However, as people who met sampling criteria were many, the researcher further used Modal instance sampling. Modal instance sampling involves inclusion of only the so-called "typical case" for the study at hand (Brink et al. 2018: 126).

### ***Inclusion criteria***

The following were the inclusion criteria for participation in this study:

- Being an adult aged eighteen years and above.
- Staying in Bushbuckridge.
- Being of Tsonga origin and able to speak Tsonga fluently.
- Involved or being knowledgeable about Tsonga cultural practices or HIV management.
- Willingness to participate and to be audio-recorded.

### ***Exclusion Criteria***

The following individuals were excluded from participating:

- Being mentally disturbed.
- Staying in Bushbuckridge being not of Tsonga origin.
- Limited knowledge of Tsonga cultural practices.
- Unwillingness to be audio recorded
- Being mentally challenged.

The total sample comprised of 19 key informants from different backgrounds, as presented in chapter 4. Reason for using different categories of informants was part of triangulation. Triangulation refers to the use of multiple methods or perspectives to collect and interpret data about a phenomenon, to converge on an accurate representation of reality (Creswell & Poth 2018: 328; Brink et al. 2013: 218; Grove et al. 2015: 513). Triangulation was done through the use of different sources. Tsonga men and women

from different backgrounds who volunteered to take part in the study were involved as multiple data sources for this ethnographic study (Brink et al. 2018: 84).

### **3.4.4 Data Collection**

Data collection refers to the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study (Grove, Burns & Gray 2013: 733; Creswell & Poth 2018: 148). This section presents the data collection instrument and data collection process.

#### ***3.4.4.1 Data collection instrument***

Before data were collected, an interview guide was developed. The interview guide was composed of open-ended questions and the use of prompts helped to reveal the emic view of the respondents (Grove et al. 2013: 271) so as to understand behaviour from within the culture (Grove et al. 2013: 693); and have meaning about the respondent's point of view (de Vos 2011: 417).

The guide was written in English and translated to Tsonga to ensure a better understanding of the respondents and to ensure that there is no limitation due to the usage of non-mother tongue language. After the interview guide was developed, the piloting of data collection was done by interviewing one adult who meets the inclusion criteria. The language used was Tsonga. The interview was audio-recorded and transcribed. The transcript was given to the supervisor to check. Though the supervisor was not Tsonga speaking, her comments was that the transcript looked like the key informant was interviewing the researcher because of the lengths of researcher's comments and also that the researcher seems to be leading respondent and being judgmental. The supervisor gave the transcript to the experts in the Tsonga language who mentioned that the question asked in Tsonga, was not meaning what the researcher meant in English. The experts in Tsonga gave the correct translation and rechecked the entire interview guide. The interview guide was then given to another academic who is also an expert in Tsonga language who translated the interview back into English to ensure that the meaning is not lost. After correction of the interview guide, a second person who also meets inclusion criteria was interviewed in the presence of the



supervisor who gave guidance regarding the interview process. The researcher was then allowed to conduct the third interview, transcribe and resubmit to the supervisor. After the third piloting, the interview guide and the process were considered as correct, and the researcher received permission from the supervisor to continue with data collection (The final interview guide is attached as Appendix F).

#### **3.4.4.2 Recruitment of the Key informants**

To recruit the key-informants, the researcher approached Primary Health Care facilities to request permission to recruit respondents. The researcher showed the facility manager the permission letter and also the ethics clearance from the University of South Africa, Department of Health Studies Research Ethics Committee. On receipt of permission, the researcher introduced herself, and that she is a Ph.D. student conducting the study and mentioned all aspects related to the study including all the relevant ethics aspects as discussed under the ethics section. Each informant was given an information leaflet to take along. Some key informants who were not health care professionals were recruited from their homes based on the researcher's knowledge of the role those individuals play in relation to cultural practices. Those who were willing to participate voluntarily were requested to identify date, time and place which will be suitable for conducting interview.

#### **3.4.4.3 Interview Process**

Key-informants who accepted to participate were visited at the predetermined time and venue. Before starting the interview, the researcher reiterated the ethics aspects as written in the information leaflet. Participants were given time to ask questions where they do not understand. The issue of voluntary participation and the right to withdraw anytime was also re-emphasised. When the informant indicated understanding, they were requested to sign consent form. Before continuing with the interview, a test audio recording was done for a minute to ensure that the recorder is functioning properly, and the voice is audible.

To initiate an interview, key informants were first asked questions related to demographic aspects in order to make them feel relaxed. The interview was conducted in Tsonga language. This was followed by the following grand tour question as indicated in the interview guide: *"Kindly share with me the Tsonga cultural practices and beliefs that*

*may increase the risk of HIV infection among Tsonga people in Bushbuckridge.*” Follow-up questions in the form of probes were used to ensure that key informant provides more information or clarify the information provided. Probing is a technique used during interviews to obtain more information in the form of asking questions for prompting the respondent to explain more on what is discussed (Grove et al. 2015: 509; Grove et al. 2013: 705; Brink et al. 2018: 144). The probing process was done until the key informants had nothing new to say in this regard. Apart from probing, the researcher was paraphrasing what the participant has said and also using minimal encouragers to encourage the key informant to provide more information.

After exhausting all the responses, the researcher asked the Key informants if there is still more information which they needed to add in relation to all the core questions or anything related to culture and HIV. When the informants mentioned that they had exhausted all the responses, they were thanked and be informed that they will still be contacted for follow-up interview, member checking and also to communicate the outcome of the study.

Observation notes were taken (Grove et al. 2015: 504; Mouton 2001: 320) to record all aspects which have been observed during the interview or in the environment where the key-informants live which seems relevant to the study topic but could not be audio recorded (Botma et al. 2015: 204). Some of the fieldnotes information included the type of attire, the tattoos, number of people who were seen in the family, activities happening in the family, and the type of buildings. Some of those observations also guided some follow-up and probing questions. For example, *“I have seen that you have a tattoo, let’s talk more about it”; I have seen when I enter your pace, that there are so many houses in this yard, may you kindly explain what is happening?”*

### **3.4.5 Data Analysis process**

Data analysis is a systemic organization and synthesis of the research data (Polit & Beck 2017: 725). Data analysis in qualitative research involves a process of inductive reasoning and thinking (de Vos 2011: 399). It involves sorting, questioning, thinking, and developing themes from the raw data (Botma et al. 2015: 221). Creswell and Poth (2018:

181) define data analysis as a process consisting of careful reflection and grouping or clustering information into specific categories and themes. This study by being ethnographic it required cultural emersion (Tjale et al. 2004: 250). To achieve that, the researcher used ethnographic content analysis to analyse data. Content data analysis is a method that examines communication messages that are usually in written form” (Brink et al. 2018: 210). In order to ensure that the content is in a written form, before commencing data analysis, all data elicited from informants were transcribed verbatim and sent for translation into English by an academic who is an expert in the Tsonga language. To ensure that translation was correctly done, five translated transcripts randomly selected were sent to another academic who is also an expert in Tsonga to translate the transcripts back in English to ensure that the meaning was not lost during the process of translation.

The transcripts and the observation notes were analysed simultaneously using steps for ethnographic qualitative content analysis, as stated in Brink et al. (2018:31) as follows: The researcher read through the first transcript thoroughly in relation to the observation notes. The researcher immersed herself in the data by reading and re-reading the data provided to organise, reduce, and give meaning to data (Grove et al. 2015: 502). In the process of reading and re-reading the transcript, the researcher tries to identify the themes. Similar themes were linked and combined into one broad theme called super-ordinate theme. The researcher developed a table of master theme composed of superordinate themes, themes, and sub-themes. The researcher repeated the same process until the final transcript. This process was then followed by looking at all tables of themes from individual transcripts refined and even join other themes to come up with final table of themes consisting of super-ordinate themes, themes, and sub-themes. The same process was followed by an independent coder who was knowledgeable in ethnographic study and also Tsonga cultural practices and beliefs. The table of themes from the researcher and the independent coder were compared and discussed until there was a final integrated table of themes, as indicated in chapter 4. The table guided the final report writing outlining the meanings inborn in the participant’s cultural practices and beliefs (Bryman et al. 2014: 351). Throughout the study process, the researcher has

tried her best to ensure the rigour of the study. Rigor is defined as a way or means taken by a researcher to strive for excellence in research (Grove et al. 2013: 708). Rigor was ensured through ensuring trustworthiness.

### **3.5 TRUSTWORTHINESS**

Trustworthiness refers to the strengths of qualitative study determined by evaluating all study aspects (Grove et al. 2015: 513). Issues of trustworthiness were taken into consideration as a way of ensuring the rigor of the study (Brink et al. 2018: 82). Two outstanding authors Lincoln and Guba (1999) cited in de Vos (2011: 491) state that the truth value of research studies can be properly ascertained through the use of the four criteria. These four criteria were found to be relevant in assessing the quality of qualitative research. They include credibility/authenticity, transferability, dependability, and conformability.

#### **3.5.1 Credibility**

Credibility refers to the truthfulness of the data and analysis thereof – thus the ability to believe the findings and interpretation thereof (Grove et al. 2015: 502; Polit & Beck 2008: 539). Credibility is described as the confidence that one can have regarding the truth value of what has been found in a research study (Polit & Beck 2008: 554). The researcher also triangulated data from the ethnographic interviews using multiple data sources and available literature sources to arrive at credible data and inferences. In this study, the researcher conducted the study in the community and primary health care facilities and used audio recorder during the in-depth interviews. Observation notes were also taken as a means of ensuring the triangulation of data sources. Triangulation was also ensured through the use of multiple data sources through conducting in-depth individual interviews with a wide range of key informants as indicated in chapter four under the section of biographical data. All these strategies ensured that the study was credible. Expert independent Co-coder were involved in analysing of the transcripts to enhance the credibility of the findings

A reflective diary and observation notes were kept documenting the context, environment, and non-verbal communication. The researcher used member checks such as probing

and paraphrasing for confirming and reflecting the understanding; meaning and any uncertainties where appropriate. A thick description of the context, flow, and contents was provided to validate inferences made, and the process followed. Verbatim transcription and also translation were done to ensure that the meaning from informants is not lost. Audio recorded information was saved in a memory stick in case there is a need for further validation of the information. Each theme is backed up by the excerpts from key informants' transcripts.

### **3.5.2 Dependability**

Dependability refers to the reliability of data over time and the conditions under which it was obtained (Brink et al. 2018: 159). Dependability relates to credibility and underlines the truth-value of the data as provided. Dependability also relates to the stability of the data over time and conditions (Brink et al. 2018: 111; Grove et al. 2015: 502), even if repeated with similar participants in the same context. The researcher clearly described the study setting, sampling process, the interview, and data recording process. An external editor was used to review the audit trail and thus confirm whether dependability has been achieved (Polit & Beck 2008: 748). The supervisor checked if the study is dependable. Research document such as transcripts, observation notes, and copies of audio- recordings are kept safe if one needs to verify that the content is acceptable and dependable and to attest that there is data to support the findings (Brink et al. 2018: 159). The coding was done and also done by an independent coder. Two different experts were used in translation of transcripts where one translated the Tsonga transcripts into English while the second independent translator translated five randomly selected transcripts back to Tsonga language to ensure that meaning is not lost in the process. Piloting of interview guide and interview process was done before actual data collection process. The researcher was monitored by an expert, a professor who is the supervisor for this research.

### **3.5.3 Confirmability**

Confirmability relates to the need to remain as objective as possible throughout the study (Creswell & Poth 2018: 256). This is done to ensure that the findings as presented and

analysed are truly from the perspective of the key informants. Polit and Beck (2008: 539; 750) state that confirmability “refers to the objectivity or neutrality of the data”. Tjale and de Villiers (2004: 254) state that participants should confirm if interpretation by the researcher is precisely within what was reiterated by the participants during data collection and as such credibility is ensured. The researcher confirmed the information and was assisted by recordings that could be listened to again and again and was able to translate raw data from Tsonga to English. Triangulation also enhanced confirmability (Brink et al. 2018: 159). The researcher was able to ensure objectivity based on the independent coders who analysed raw data and quotes that emerged.

In these criteria, the researcher should have another researcher who can confirm the findings of the study Lincoln and Guba (1999) cited in (de Vos 2011: 421). The process is undertaken by a person who audits the work and should confirm or “guarantees” that what was revealed by the study, conclusion, and recommendations are based on facts. There should be evidence to support what the researcher interpreted. A fully performed procedure on auditing should be followed (Brink et al. 2018: 159). In this study the supervisor who is an expert in the field of qualitative research and who has supervised ethnographic studies before reading to confirm that what has been said and transcribed was properly written and interpreted to be correct findings, conclusion, and recommendations that should be in line with the data collected. This was done in comparison with transcripts of recordings. Through the in-depth interviews of multiple data sources, the researcher was able to follow the procedure of confirmability objectively. Evidence was confirmed on the findings and interpretation (de Vos 2011: 421). Since all interviews and discussions were recorded confirmation process was possible for the researcher through checking against the transcribed data.

#### **3.5.4 Transferability**

Transferability refers to the possibility of transferring findings of a research study from one area to another (Brink et al. 2018: 159). The possibility of transferability can also be ensured when the study has been involving multiple data sources. The findings of the study are transferable as there were multiple data sources, detailed description, purposive sampling, and data saturation (Brink et al. 2018: 159). In this study, the

utilization of purposive sampling, thick descriptions of findings, data saturation, and audit trails contributed to transferability (Brink et al. 2018: 159). In this study, findings on risky cultural practices that may promote the spreading of HIV/AIDS in the Tsonga community of Bushbuckridge may be transferable to other communities who are belonging to the Tsonga ethnic group in Limpopo, also in some parts of South Africa as confirmed by Statistics South Africa for first languages used in provinces. Most parts of the Limpopo province which was known as Northern Province are inhabited by Tsonga people who occupied the Gazankulu homeland. Some are found outside the borders of South Africa, such as Mozambique, Zimbabwe, and Zambia (Mathebula 2013: 14; Afolayan 2004: 16). The Tsonga ethnic group has similarities with the Nguni cultural group such as polygamy, men's habit of multiple concurrent partnerships and widow inheritance among the Zulu community (Mogotlane et al. 2007: 35).

There can be transferability to other Tsonga people outside Bushbuckridge, except the Tsonga there may be transferability of the findings of this study as literature has proved that other African cultures have similar cultural practices. These include the Zulu and Swazi community (Afolayan 2004:16), and in some African cultures in central Africa. Some of the cultural practices identified to exist even outside the Tsonga culture is patriarchy, authority by males, polygamy, special recognition to boys more than girls, the inferior position of women in the community, wife inheritance and others (Afolayan 2004:182, 185). The findings helped to develop "A cultural approach model for HIV and AIDS prevention and care regarding HIV risky Tsonga cultural practices and recommendations to address such practices. In consultation with Bushbuckridge sub-district HIV and AIDS managers, local HIV and AIDS council, traditional leaders, traditional healers, and all other stakeholders, the model can be used to empower Tsonga community to modify or refrain from HIV risky cultural practices. Issues of trustworthiness cannot be achieved if the study was not ethically conducted. The next section focuses on ethical considerations.

### **3.6 ETHICAL CONSIDERATION**

Ethics is defined as the moral principles governing or influencing conduct and the branch of knowledge concerned with moral principles (Concise Oxford Dictionary 2011: 490). A

researcher must ensure that a research study is conducted in an "ethical manner" (Brink et al. 2018: 27). Research and ethics are inseparable. It is important to consider ethics when researching at a PHC setting (McClellan 2012: 287). A researcher cannot conduct a study without considering ethics seriously, and one cannot only consider ethics without conducting research scientifically (Brink et al. 2018: 27). Ethics in research involves being able to know what is right and what is wrong when conducting research and be able to justify ethically the reason for conducting specific research in a certain way (McClellan 2012: 288). This helps a researcher to "conform" to what is acceptable in as far as morals are concerned (Mouton 2001: 238). It is important to ensure that ethical issues are complied with when conducting a study that has to do with the cultural phenomenon (Tjale & de Villiers 2004: 265).

Ethical issues are said to be more important especially when dealing with human subjects and must be considered when recruiting participants, during intervention process and for releasing results (Welman et al. 2010: 181) and throughout the different phases of the research process (Creswell & Poth 2018: 54). This is critical in HIV and AIDS since social justice is also important (McClellan 2012: 286). The researcher in this study was enabled to ensure that ethical issues are taken into consideration as this forms part of what is expected of a nurse professionally which is what the researcher has been involved with for many years when dealing with human beings as part of her work which is what is import in research.

An ethnographic study of cultural practices involves human beings. Tjale and de Villiers (2004: 255) say that "Ethics and research are inseparable and also that ethical issues are inherent in qualitative research". An outline of ethical issues that must be taken into consideration includes self-determination, informed consent, privacy, confidentiality, anonymity, dignity, and refusal to participate (Tjale & de Villiers 2004: 256). This section focused on ethical consideration as it is critical to outline ethical principles that were taken into consideration for this qualitative, ethnographic study.

For this study, ethical clearance were obtained from the Universatity of South Africa (Annexure A) and the Department of Health in Mpumalanga (Annexure C).



### **3.6.1 Privacy**

It is a must for a researcher to respect the privacy of participants (Leedy & Ormrod 2013: 107). It is an aspect of human rights and needs to be protected. In this study, the right to privacy was prioritized. All informants were interviewed in privacy (Brink et al. 2018: 35). Participants are not supposed to be exposed to an embarrassing situation (Leedy & Ormrod 2012: 105). De Vos et al (2011: 119) state this issue clearly; privacy means that a person has a right to keep issues that should not be observed or analysed by someone else. Based on the above explanation, privacy was ensured to all informants at the health care facilities and their homes so that informants' privacy can be maintained. Privacy is important for informants as persons and what they were saying and doing during interviews. Informants' privacy was not violated at all. As a researcher, it was of utmost importance to do all possible means to protect and maintain the privacy of all those who took part in the study (de Vos et al 2011: 121).

All interviews were conducted in privacy where people could not see the process or hear the conversation. Informants were enabled to exercise their freedom to determine the time, extent, and any other circumstances under which they could share or withhold information (Grove et al. 2013: 705). All possible measures were taken by the researcher to ensure privacy during the study, data analysis, and documentation of findings.

### **3.6.2 Anonymity**

All informants in the study were treated anonymously. Any information that could expose informants' identity has not been revealed. A description of any information should not be attached to a person. Instead, a pseudonym can be given (Leedy & Ormrod 2012: 108). Anonymity is one of the important or fundamental ethical principles that must be considered. No names were used during the interviews or for research report writing. Anonymity should not only be promised in writing but should surely be guaranteed. Tjale and de Villiers (2004: 260) say that privacy, confidentiality, and anonymity are issues that should be taken into consideration in qualitative research even when it comes to publication.

In this study no informant's name or identity was made known to others; on the other hand, de Vos (2011: 120) state that "information given anonymously ensures the privacy of the subject." It will be possible for informants to remain private since they were not identified; thus, anonymity was ensured. Even the use of devices should be understood by the participants following the explanation of how they work (Mouton 2001: 243). A recording device used during data collection was fully explained by the researcher before it was used. The researcher got explicit permission to use things such as tape recorder (Setswe, Naude & Zungu 2011: 379). In this study, a specific consent form was designed to use a voice recorder specifically.

### **3.6.3 Confidentiality**

One of the human rights that must be protected by a researcher is the right to confidentiality (Brink et al. 2018: 31; de Vos 2011: 119). According to de Vos (2011: 119), confidentiality refers to "the handling of information in a confidential manner," while Brink et al. (2018: 30) defines confidentiality as a process whereby the identity of the research participants is known only to the study investigator (s). Confidentiality is not a once-off activity but a process whereby the researcher makes sure that all the information collected during the study should not be associated or linked with specific informants, in addition such information should never be divulged to any other person (Brink et al. 2018:31). The researcher ensured that there is no breach of confidentiality; this means that no unauthorised persons had access to the data collected. The human right to confidentiality was not violated throughout this ethnographic study. According to the National Patients' Rights Charter 2.7 "information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or any order" (Department of Health 2016: 18). Confidentiality refers to "management of private data in research to ensure that the identity of subjects is not associated with their responses" (Grove et al. 2013: 690). The researcher in line with her job of nursing and as researcher continued to promote the rights of informants including privacy, anonymity, and confidentiality, which are in line with ethics and the field of nursing.

### **3.6.4 Informed choice to participate**

Participants need to exercise their rights for choosing to participate or to decide not to participate in a study. This should be exercised without fear of being penalised. The right to choose to participate should be freely exercised to such an extent that even if the participant wants to withdraw, such withdrawal should be done at any time of the study. Information was given verbally and in writing (Brink et al. 2018: 32). Xitsonga language was used to ensure understanding. The informant had the option to withdraw, as outlined above (Brink et al. 2018: 34). It can be in the middle of the interview and not anticipating any penalty. When participants exercise this right, under no circumstances should a researcher fine a person or coerce (Brink et al. 2018: 35) or impose any form of penalty even if it is a refusal of giving some information or explanation of something in detail by the researcher. Key Informants were allowed the opportunity to choose to participate if comfortable and not to participate if they do not want without being penalised.

Voluntary participation is an aspect of ethics that should be promoted at all times. Only participants who choose to take part in the study voluntarily formed part of the sample. The consent form stipulated the freedom to participate when a person feels comfortable. The explanation was done regarding the right to choose to participate or not before interviews could be conducted. Also, the consent forms were available in English and Tsonga so that informants can understand the content, which is their first language.

### **3.6.5 Informed consent**

According to Brink et al. (2018: 34) informed consent refers to the voluntary agreement made by the participant to take part in a research study after receiving information with a full understanding of what the study will involve before a study can be undertaken. According to de Vos (2011: 118), informed consent is compulsory, and a researcher must not violate this right. A researcher is legally bound to give information in the form of a complete explanation of the study in full. The researcher gave information in simple language and ensured to be as clear as possible. Participants are in a position to choose to give consent or not Babbie, and Mouton cited in Brink et al. (2018: 34). Institutions, where data was collected, were also informed in writing regarding what the study involves

so that permission was given with knowledge and understanding of what was going to transpire during the study (de Vos 2011: 118). The researcher gave information to those who volunteered to participate in the study and allowed that questions be asked before informants could take part in the study. Informants were addressed in their language, “Tsonga.” This ensured that there is a full understanding of what took place as such gave consent based on the information given by the researcher. Letters were written to request permission from the authorities at the district, sub-district and PHC facilities where the study was conducted. The study was conducted following permission and authorisation to do so. Brink et al. (2018: 31) explains that informed consent refers to participant’s degree of understanding about the research and “to choose whether or not to grant consent.” Full disclosure of the study was done by the researcher to all those who volunteered to take part in the study. It is important for a researcher to thank the Informants following their participation (Mouton 2001: 244). Key informants were thanked for their contribution.

Informed consent is defined as the “prospective subject’s agreement to voluntarily participate in a study which can be possible when the subject has understood the information given (Grove et al. 2013: 697). Informed consent or full disclosure should include specifying the institution where the researcher comes from, indicating the people who will benefit from the study, explaining what the researcher is intending to do and asking for permission for what was done during the study, the risks anticipated, freedom to opt-out of the study at any time, confidentiality and debriefing (Mouton 2001: 244). All steps under debriefing should be handled by the researcher fully. In this study, full disclosure (informed consent) was given full attention through the use of full information outlined on the consent form. The University had already issued a clearance certificate, and approval for the study was received from the Mpumalanga Provincial Ethics committee and Bushbuckridge sub-district office.

Informants got full information on what was going to take place during the study and signed the consent to confirm that they agreed to take part in the study. Informants were informed that there were no physical risks and that they may decide to opt-out without penalty (Brink et al. 2018: 36). Confidentiality was maintained, and it is something that

was fully discussed with the Informants (Mouton 2001: 244). The researcher remains obliged to give a full explanation of what an ethnographic study involves (de Vos 2011: 118). In this case, everything was outlined regarding research on risky cultural practices that may promote the spread of HIV in the Tsonga community and affecting its management this was the focus of the study.

### **3.6.6 Respect**

The principle of respect for persons is one of the fundamental principles of ethical consideration (Grove et al. 2013: 708; Brink et al. 2018: 35), the respect for persons include the fact that people are autonomous, making them have a right to self-determination. Self-determination makes a person have a right to decide on whether to participate or not in the study. Respect for persons is said to be one of the “basic ethical principles in human research” – the reference in line with the summary of the Belmont report of 1974. Human beings are supposed to be treated as autonomous persons. Against this background, the research design of the study being ethnographic, informants must be treated with respect and courtesy at all times (Leedy & Ormrod 2013: 105). Respect and dignity are part of the sub-domain of the Patient Rights where staff at hospitals and clinics are expected to treat patients with respect, courtesy and empathy (Department of Health 2016: 18) according to the National Core Standards of South Africa. Respect during this study was promoted without difficulty as it is a continuation of what the researcher is doing during her professional duties as a nurse.

### **3.6.7 Autonomy**

Individuals must be treated autonomously (Grove et al. 2013: 164; Brink et al. 2018: 29). An autonomous person can exercise freedom of action. The researcher should disclose fully the nature of the study, the benefits or risks that may be encountered when a person participates in the study and allow time to ask questions about the study to be able to decide to participate in the study or not. According to Tjale and de Villiers (2004: 222), autonomy refers to one ‘s authority to make decisions about his/her values.

In this study, all key Informants were given full information about the ethnographic study on cultural practices of the Tsonga ethnic group so that they exercise their freedom of

action meaning that they could participate or decide not to participate since they were autonomous.

### **3.6.8 The Right Not to be Harmed**

The process of conducting research should in no way result in the risk or any harm for those participating in the study (Brink et al. 2018: 28). Participants should not be embarrassed during the study (Mouton 2001: 245) since the study involved interviewing and recording, the chances of harm were less anticipated. In this study no form of harm or any procedures such as blood samples, physiological procedures, and psychological tests were done as part of the research. Even though this was the situation, it remains the responsibility of a researcher to protect participants from any form of harm (de Vos et al. 2011: 115) since any type of research has a potential to pose ethical concerns (MNUALL/301/0/2015: 73). No Informant was harmed during this study. Measures were in place, such as booking the psychologist in the hospital in case of psychological trauma.

### **3.6.9 Beneficence**

According to Brink et al. (2018: 29), beneficence is defined as a fundamental ethical principle that seeks to maximise benefits for study participants and prevent harm. According to Polit and Beck (2008: 748), it is highly recommended that the researcher's involvement of participants in research should result in minimal discomfort. The researcher should make sure participants in a study should benefit maximally and be exposed to no harm. Risks in a research study should be reduced by all means. It is the responsibility of a researcher to make sure that any person who participates in a study must be protected from any form of harm or discomfort. From the ethical point of view, researchers rather change research so that respondents should not find themselves to be exposed to emotional or physical harm (de Vos 2011: 116). Tjale and de Villiers (2004: 244) state that beneficence should include prevention of cultural harm by making sure that the researcher should ensure "cultural safety." In this study, Informants and the community is likely to benefit more than experiencing harm. Cultural safety was ensured by addressing them in a culturally acceptable manner. Since the researcher is Tsonga,

the application of cultural relevance prevented cultural compromise (Tjale and de Villiers 2004: 226) as it is morally wrong to compromise one's culture.

### **3.6.10 Justice**

Justice includes the protection of privacy and ensuring that data is processed anonymously (Brink et al. 2018: 30). Participants should not be unfairly selected or treated unfairly (Brink et al. 2018: 35). No Informants was exposed to unfair procedures of selection. According to Grove et al. (2013:698) the principle of justice refers to a situation where "human subjects should be treated fairly". A researcher 's responsibility is to make sure that participants are selected in a manner that allowed distribution fairly, secondly selection of participants should be made taking into consideration equity (Brink et al. 2018: 30). The researcher implemented the principle of justice by being fair when selecting informants and interacting with them fairly throughout the research period. Informants who took part in the study were involved voluntarily, based on their interest to take part. They were informed that they were free to withdraw anytime without any penalty.

### **3.6.11 Debriefing**

Debriefing is defined as the "complete disclosure of the study purpose and results at the end of the study (Grove et al. 2013: 691). Debriefing refers to a period where by the subjects are afforded sometime after the study to go through the experiences they had during the study. It is important to have these sessions because of multiple factors: -

- There may have been some misconceptions; this will allow clarifying such mistaken views or wrong opinion
- It also helps to complete the learning experience that took place during data collection and helps the participants to become more knowledgeable about the study
- It allows support of the participants and can be involved in therapy and participants can go through their experience
- It can reduce uncomfortable reactions experienced by participants

- The researcher can become aware of certain participants that may need to follow up intervention during a discussion with the researcher (de Vos 2011: 122)

Debriefing is defined as a situation where one is questioned following a completed undertaking (Concise Oxford Dictionary 2011: 369). In this study, debriefing sessions were conducted as indicated in the first chapter. In the case of Informants who experienced unwanted psychological effects, such participants were to choose health professionals who could provide care for them. The social workers were available at the clinics and hospitals. They could be approached for debriefing. A psychologist at the referral hospital was booked to be involved with those who might need psychological or medical services. Referral letters to the Hospital could be helpful for them to do a consultation. No key informant experienced a situation which warranted referral for psychological attention.

### **3.6.12 Honesty with Professional Colleagues**

A researcher displayed honesty with professional colleagues. The findings were outlined while taking into consideration honesty. Data fabrication should be avoided at all cost. All sources were acknowledged (Leedy & Ormrod 2013: 108). Scientific honesty must be respected fully. There should be no fabrication and no falsification of data (Brink et al. 2018: 36). There was no manipulation of research design and research methods. There was neither selection of specific data in favour of the researcher nor any manipulation of data. In this study, sources in the form of articles, books, or health records were used for literature and were acknowledged fully. Data did not reflect the perspective of the researcher (Brink et al. 2018: 36). All the work was supervised by an experienced professor. The research method and design used were appropriate for the study, qualitative methodology and ethnographic design respectively have been found to be suitable for a study that deals with cultural issues. Data was reflected as it is to reveal exactly what transpired and was reported by Informants. Plagiarism, which is copying the work of others was avoided, and the university has strategies to detect plagiarism (de Vos 2011: 122; Brink et al. 2018: 36). Sources used were acknowledged, and findings were reported accurately. Brink et al. (2018: 36) say that one other important thing is that data should not be manipulated by the researcher to favour intended findings. Under no



circumstances should conclusion and recommendations be based on intentional false (Tjale & de Villiers 2004: 262). The use of voice recorder and transcripts helped to confirm data and thus help to prevent any fabrication.

The patients' rights charter is stipulated under the National Core Standards for the health care services (Department of Health 2016: 17). It is important that health care workers create an environment which promotes the rights of the patients. Firstly, some of the rights include the right to dignity, to a safe environment, choice of health services, confidentiality and privacy, informed consent, and refusal to treatment. These rights are in line with what is expected of a researcher. Informants and patients are human beings and should be treated ethically even in relation to research studies. Domain number one (1) of the patient rights says that staff should treat patients with care and respect, taking into consideration choice and privacy, which must be maximised. Point number 1.2 states that information should be given regarding care of patients and "their participation in research "The researcher was in a position to continue with these rights as it is in accordance with "Batho Pele "principles (Department of Health 2016: 18) which are the principles on patient first which relate directly with ethical principles. The researcher ensured that all ethical principles were taken into consideration.

### **3.7 PHASE 2: MODEL DEVELOPMENT**

Phase two of the study focused on the development of a contextual, cultural approach model for HIV and AIDS management reflected in chapter 6. The cultural approach model for HIV and AIDS management was developed based on the research findings in phase one of the study which was situational analysis based on research questions one and two namely: (i) What are the Tsonga cultural practices and beliefs that may increase the risk of HIV infection among Tsonga people in Bushbuckridge? and (ii) What can be done to mitigate cultural practices and beliefs that negatively affect the management of HIV and AIDS among Tsonga people in Bushbuckridge? Leininger theory of Culture Care Diversity and Universality and the literature review also formed the basis for developing this model. To organise all the aspects into a model, the researcher followed Chin and Kramer (1999: 74) and Walker and Avant (1995: 39) theory development designs and methods. The design uses the concept analysis, synthesis, and derivation.

### **3.3.1. Concept Analysis**

Concept analysis refers to a mechanism for identifying a set of characteristics that are essential to give meaning to a particular concept (Walker & Avant 2011: 160). The purpose of concept analysis is to clarify the concepts that are not clear or outmoded. In this study, this process formed the basis for developing contextual cultural approach model for HIV and AIDS management for Tsonga people in Bushbuckridge. According to Walker and Avant (2011: 160), the first and most important step in conducting concept analysis is concept selection. Therefore, in this study, the concepts “culture”, “cultural practices”, “Health care professionals” and “management” were selected and described and utilised in the context of the study. Management was utilised to include cultural congruent modalities, which include preservation, accommodation, and re-patterning as terms used in Leininger theory of culture, care diversity and universality. After careful thorough literature search and interviewing the key informants, the researcher realised the concept management in relation to HIV and AIDS include aspects such as prevention of HIV infection through avoiding spread or contracting HIV. The term also includes offering treatment including Antiretrovirals and traditional medicines. Management of HIV and AIDS also include how HIV is viewed and what are its causes from cultural perspectives and how people living with HIV are cared for. This concept tally with the Leininger theory of culture care diversity and universality. The HIV and AIDS management could not be viewed without focusing on culture of people involved, their way of care, diverse approaches to HIV and the universal requirements in relation to HIV and AIDS management. Health Care practitioner was used as an inclusive concept for both traditional health care providers and the health providers who are focusing on western way of provision of care. For all these aspects to be integrated, the researcher used the elements of Schreens (1990)’ CIPO (Context, Input, Processes and Output) model to organize the model.

### **3.3.2. Synthesis**

According to Walker and Avant (2011: 107-118) synthesis refers to the generation of new ideas by examining data of new insights or develop statements about relationship through observations of phenomena. As concept synthesis begins with raw data, the researcher

was guided by literature review in relation to HIV and AIDS management, in-depth interview of key informants and observation notes in relation to Leininger's theory of culture, care, diversity and universality. This facilitated the development of a contextual cultural model for managing HIV and AIDS. The researcher also utilised the elements of CIPO model to guide identification and organisation of key and relevant concepts for the model. The relationship of all these elements within the context of CIPO model assisted in showing the relationship of different aspects of the contextual cultural approach model for HIV and AIDS management

### **3.10.3 Derivation**

Derivation is a situation where the researcher finds no concept to explain a phenomenon (Walker & Avant 2011: 118). The process involves transposing or redefining a concept or theory from one context to another. This is done through a critical examination of a selected concept to find its meaning and also modifying the concepts to fit the required meaning and consistency in health concepts. The researcher adopted theory derivation in conducting both phases of the study, including describing, interpreting the Informant's responses and linking the research findings with the literature reviewed. Some of the concepts which were only available in Tsonga language were defined.

Furthermore, the researcher developed the contextual cultural approach model for HIV and AIDS management following CIPO model. Therefore, the purpose and process of the derivation are defined by Walker & Avant (1995) as getting strategies of explanation and prediction of a phenomenon which is poorly understood and no means to study it. This was important in this study as there are certain Tsonga cultural practices and beliefs which were not easy to understand. In order to thoroughly understand and utilize the term properly in relation to the model development, the researcher sent the developed model for evaluation by experts. Feedbacks from experts were received and the model was revised in line with their suggestions.

### **3.11. CONCLUSION**

This chapter outlined research methodology which is qualitative, ethnographic research design, the purpose of the study, aim of study, research question, research population,

sample and sampling technique, data collection format, pretesting of interview guide, data collection, data analysis, ethical consideration, credibility, dependability, confirmability, transferability and how each one of them was addressed and implemented by the researcher and ethical principles were taken into consideration. The chapter also provided an overview of model development.

## **CHAPTER 4: PRESENTATION OF THE RESULTS**

### **4.1 INTRODUCTION**

The previous chapter (chapter 3) focused on research methodology used for both phases of the study, namely situational analysis and model development. This chapter presents the results of the study. Data was collected qualitatively for an ethnographic study. The first section of this chapter presents the demographic characteristics of the key informants. The second section presents the findings from ethnographic data analysis in the form of super-ordinate themes, themes, and sub-themes backed up by quotations from key informants. Literature control is also used in relation to the findings.

### **4.2 DEMOGRAPHIC DATA**

All key informants were Tsonga speaking and resided in Bushbuckridge. A total of 19 key informants who meet the inclusion criteria participated in the study. Their demographic data is displayed on table 4.1.

Table 4.1 Demographic data of key informants

<b>Key Informant (KI) no.</b>	<b>Educational status</b>	<b>Employment status</b>	<b>Gender</b>	<b>Age</b>	<b>Marital status</b>
KI 1	Honours	Educator	Female	34yrs	Single
KI 2	Grade 12	Unemployed	Female	28yrs	Single
KI 3	Matric	Unemployed	Female	21yrs	Single
KI 4	Grade 11	Unemployed	Female	26yrs	Married
KI 5	Standard 3	Unemployed	Female	58yrs	Married
KI 6	Grade 11	Unemployed	Female	32yrs	Married
KI 7	MBChB, Degree	Medical doctor	Male	54yrs	Married
KI 8	Traditional healer, standard 5	Traditional healer	Female	54yrs	Married
KI 9	Diploma (Admin work)	Admin clerk	Female	40	Married
KI 10	Matric	Secretary of traditional Healers	Female	49yrs	Married
KI 11	Master's Degree	Retired teacher school manager	Male	68yrs	Married
KI 12	Degree In nursing	Retired nurse (Community PHC nurse)	Female	62yrs	Married
KI 13	Degree In nursing	Retired nurse (Nurse Educator)	Female	75yrs	Widow
KI 14	Masters	Retired school manager, The writer of Tsonga books.	Male	74yrs	Married
KI 15	Degree in nursing	Nurse and unit manager	Female	62yrs	Married
KI 16	Diploma	Administrator	Male	48yrs	Married
KI 17	Masters	Lecturer	Male	54yrs	Married
KI 18	Standard 3	Pensioner	Female	85yrs	Widow
KI 19	Grade 12, HIV counselling	HIV Counsellor	Female	38yrs	Married

The ages of the participants range from 21 to 85 years. All key informants were of Tsonga origin and Tsonga speaking. They are knowledgeable of Tsonga culture or involved in management of HIV and AIDS.

#### 4.3 EMERGENT THEMES

The findings of this study revealed four superordinate themes ranging from language, rituals, beliefs related to the origin of diseases and cosmetics. Each superordinate-theme has several themes and sub-themes as indicated in table 4.2.

Table 4.2 Summary of themes

<b>Superordinate-themes</b>	<b>Themes</b>	<b>Sub-themes</b>
<b>Language</b>	<b>Proverbs</b>	<i>Promotion of multi concurrent relationships</i>
		<i>Discouraging men from expressing emotions</i>
	<b>Songs</b>	<i>Promoting engagement into sexual activities</i>
		<i>Praising multiple concurrent behaviours</i>
		<i>Promoting polygamy</i>
	<b>Clan names</b>	<i>Promoting polygamy and extramarital Relationships</i>
		<i>Promoting sex before marriage</i>
		<i>Promoting engagement in sexual activities</i>
	<b>Taboos</b>	<i>Lack of sexuality education</i>
<b>Rituals</b>	<b>Initiation schools</b>	<i>Male circumcision</i>
		<i>Female circumcision</i>
	<b>Post-death</b>	<i>family protection</i>
		<i>Cleansing of the widow</i>
		<i>Partner inheritance</i>
	<b>Marriage</b>	<i>Arranged marriage</i>
		<i>Treatment of Infertility</i>
<b>Beliefs related to the origin of diseases</b>	<b>Witchcraft</b>	
	<b>Ancestral call</b>	
	<b>Punishment by ancestors</b>	

<b>Traditional healers</b>		
<b>Tattoos</b>		

#### 4.3.1 Language

According to Mogotlane, Chauke, Matlakala, Mokoena and Young (2014: 22), the first component of culture is language. Language is defined as the method of human communication, either spoken or written (Concise Oxford Dictionary 2011: 801). According to a dictionary for Xitsonga to English, Dikixinary ya Xitsonga / English Dictionary (2006:134) language is a noun called *ririmi* or *mavulavulelo*. The Tsonga language has different expressions, which include proverbs, which can amount to almost one thousand six hundred and seventy-one (Junod 2010: 8). This first superordinate theme of language is composed of four themes, which are: proverbs, songs, clan names, and taboos.

##### 4.2.1.1 Proverbs

This theme focuses on the Tsonga proverbs, which have an impact on the management of HIV and AIDS. A proverb is called “*xivuriso*’ (Marhanele & Bila 2016: 888). According to a Tsonga grammar textbook Rivomba ra Vutsonga a proverb “*xivuriso*” can combine knowledge “*vutivi*”, wisdom “*vutlharhi*” and advice “*switsundzuxo*” and one proverb can have different explanations (Lambane & Mthombeni 2014: 196,197). Proverbs preserve the culture of Vatsonga and teach a cultural group in a wise manner (Malungana 2006: 97). Proverbs are used to depict “various aspects of social and spiritual life of the Tsonga” (Junod 2010: 9). The subthemes that were covered by this theme (proverbs) include the promotion of multiple-concurrent relationships, discouraging men from expressing emotions and encouraging women to persevere in marriage.



#### 4.2.1.1.1 *Promotion of multiple-concurrent relationship and condoning of multi-concurrent relationships*

According to a Tsonga dictionary, one of the proverbs concerning issues of men says, “*wanuna l nhwembe wa nava*” (Marhanele & Bila 2016: 778). The meaning of this proverb is that a man is not prohibited from marrying many wives. The quotations below reflect how the Tsonga people believe in this proverb and how men live their lives in line with this proverb.

*“Another thing that may contribute to the spread of HIV among the Tsonga community of Bushbuckridge is that they believe that a man is a man by having multiple partners. This is mostly promoted by this proverb “wanuna wa nava i n’hwembe. Even if you complain to the relatives about the cheating husband, they don’t support, but just say that ‘wanuna wa nava i n’hwembe?” (KI 1)*

The proverb “*wanuna wa nava i nhwembe*” means that in the Tsonga culture a man has rights to have as many wives as he wishes, beyond that, he can have as many multiple sexual partners as he wants. This is something permissible. The spread of HIV can be possible as multiple concurrent partners may lead to high risk of contracting infection, especially where there is unprotected sex (Evian 2011: 67). According to Mogotlane et al. (2014: 346) the spread of HIV in Africa has been associated with multiple sexual partners engaging in unsafe sexual practices. In the following quotation a key informant gives meaning for the same proverb.

*“Shangaan proverb that says “wanuna i n’hwembe, wa nava” If you know a plant of pumpkins, we know that it can fill up a wide area being alone. This encourages that men can have the rights to have many wives; they are allowed to have multiple sexual partners. So the proverb is actually encouraging men to have many wives, and on the other hand, he can also have affairs with other women except his wives, and that can cause the spread of HIV.” (KI 17)*

It was evident that even when this proverb “*wanuna l nhwembe wa nava*” is usually applied in the Tsonga culture, the comment of the participant below suggests that other Africans have proverbs similar to the one above. According to Evian (2011: 407), some African men contract HIV as they are involved with young women and girls for intimacy and sex. This was true as in a study conducted in rural communities in Mpumalanga

Province, HIV was found to be high because the area is male-dominated and moreover the practice of multiple sexual partners is something acceptable (Madiba & Ngwenya 2017: 60). What is more of concern is that women are comfortable with a situation of having a share from a married man, this situation results in a man having different families, and on top of that concubines. The quote below illustrates what can happen following the proverb.

*“And when it comes to the proverbs and idioms that are encouraging the spread of HIV, there is one common proverb, it is found in almost all the African languages. There is one that says “wanuna i n’hwembe wa nava” and some may say “wanuna i xihloka ha lombisana”, they say that you cannot use an axe to cut alone; you need to borrow those who need it and want to use it as well. What they mean with “wanuna i n’hwembe” (pumpkin plant) it means that a man is allowed to spread to other families and have multiple relationships with women “na vona va ta khatlula nhloko, hi leswaku wanuna u va a ri na mindyangu-ndyangu “wanuna i n’hwembe”. (KI 14)*

In addition, the following quote was another experience confirming that it is expected of a man to have multiple partners because a man who is not having multiple partners is perceived to be stupid. Since men want to conform and avoid being laughed at they then “spread” as the proverb stipulates, the informant was aware that while men want to belong to “that group” the chances of contracting the disease are high. If this is the situation, it suggests that culturally, men may also be a vehicle to spread HIV in the community due to behaving like a pumpkin plant.

*“And men who don’t have multiple partners are viewed as idiots, and they are laughed at in the community, you are regarded as not being man enough, to avoid being laughed at so you need to spread and have several relationships so that one can fall in “that” group. And the more one spreads “a nava” and have those multiple relationships; it is the more one can contract the diseases (HIV).” (KI 14)*

The study findings through the quote below revealed that even in the era of HIV there are women who can put men at risk because the ratio of men to women is not equal; women are always more than men. It is this situation where men find themselves under pressure of women who confront them by asking a question which says,

*“you can’t be a man for one person, what about us, where are we going to find the one specific man for one woman”? (KI 14)*

Culturally, men are sort of compelled to prove that they are alive and show that they are man enough by being a man for several women. When men are in a relationship, they cannot resist statements from women which tempt and provoke them to prove that a man is not for one woman.

*“Women are more than men, and it is the same with us as Africans or as the Shangaan people, there are more women than men. So because of that, you find that it is no longer men that hunt for women, but women are the ones who look for a man because they say a man is not meant for one woman “wanuna i wanuna wa munhu un’we xana na?a wu nge vi wanuna wa munhu un’we, hina van’wana hi ta n’wi kuma kwini?. So if women say that, they are putting themselves on the shelves or advertising themselves and they are spreading HIV in the community in that way as well. So in that way men prove themselves to be the real men by having multiple relationships “se ku komba leswo wa hanya u fanele u va wanuna wa vanhu hinkwavo.” (KI 14)*

It is evident in the response of one of the informants below that behaviour associated with having extramarital affairs is something that Tsonga men do and even defend themselves for such things. At times it is done in combination with some form of violence as expressed by the statement which says men who are bully when they are approached having extramarital affair. According to Mathebula (2013: 10), the Tsonga people practice “vutshengwe,” meaning polygamy. *Tshengwe*” is a Tsonga word referring to a group of women married to one man (Marhanele & Bila 2016: 700).

*“Some men are bullies and when they have affairs with other women and the wife gets to find out about them and confront him; he defends himself by saying that he is doing that because he is a man. Or he defends himself by saying that his great-grandfather had three wives and she should not complain because he is only thinking of marrying two wives. And according to him, those two wives are not too much for the wife to complain about. He ends up having even more. Especially when the men are working outside Bushbuckridge because most of them are working in Gauteng”. (KI 4)*

The above quotation concurs with Evian (2011: 407) who mentioned that, men who are migrant workers had intimate relationship and sex with young women and girls when they are away from their home regardless of the number of wives they have. Some of them even engaged in unprotected sex which is risky in the era of HIV.

*“And people also say “homu i homu loko yi yimile, hi leswo loko yi karhi yi yimile hi ri homu hi liya, loko yo tshika yi wile se yi hundzuka nyama hikuva se ya dyiwa” meaning that a person is seen as a good person in daylight, but at night when they get together in the house they don’t care what they do, and they don’t care if they practice safe sex or if they are protected or not “homu i homu loko yi yimile, loko yi wile i nyama”. (KI 14)*

Regardless of the sexual practices of men such as engagement in unprotected sexual practices and extramarital affairs, a woman is expected to persevere in marriage. A key informant said the following:

*“Vukati va kandza hi mbilu” meaning that a woman has to persevere “you must tiyisela “persevere whatever you come across. She must face the challenges that she comes across. People are encouraged to stay in marriages even if they are not happy, so even if your spouse cheats on you; you must accept it as a wife. So, women stay in these relationships despite knowing that they are not happy and there is cheating; so a woman has to stomach it and try to live as if all is well.” (KI 7)*

These situations are related to how men are socialised especially in relation to expression of their emotions.

#### *4.2.1.1.2 Discouraging men from expressing emotions*

This theme is about the way men are socialised in relation to communicating their feelings especially expression of their hurt, pain, and emotions. Men are expected to be brave when it comes to difficult situations, such as being sick. It is, therefore not surprising when men do not report illnesses. Unfortunately, in the process of being brave, a man can be spreading HIV due to delayed consultation, therefore not knowing one’s HIV status can be dangerous. The following statement reflects an example of such a situation.

*“In our Tsonga culture, they always say that “wanuna u fanele ku tiyisela” (A man must persevere/ or be brave and able to endure pain and other difficult situations). So men usually don’t talk even when they have diseases that are troubling them because they were raised knowing that they have to be brave, they would rather spread the diseases and not say anything about them.” (KI 16)*

Apart from proverbs, Songs are other means of which language is expressed.

#### **4.2.1.2 Songs**

This subtheme focuses on Tsonga songs. Songs are one of the most important communication tools in the lives of Tsonga people. Songs are used in different situations for different purposes (Nkuna & Mboweni 2015: 108). Purposes of songs range from uniting people, teaching lessons, giving courage or entertainment (Nkuna & Mboweni 2015: 109). The subthemes which fall under this theme include promoting engagement in sexual activities and praising multiple concurrent behaviours

##### *4.2.1.2.1 Promoting engaging in sexual activities.*

Several songs encourage men to engage in sex. Some of the songs even promote unprotected sex especially when men refuse to use condoms as they have paid lobola for their wives (Madiba & Ngwenya 2017: 59). The following quote indicates the type of songs.

*“I do not need a thin woman because when I am with her, the bones will hurt me. I need a fat woman because when I shake there is bouncing back of fat”. The other song is, they do not choose, they chose those ones with big legs which can grasp them. The other song I know which encourage engagement in sex is the song which says” Give him (sex), it is his, he won’t finish it, just give, it is made for men, then the men will answer, yes, give it to me, it is mine, let me have it, I will not finish it.” (KI 6)*

*“Young girls sing songs like “Whose is this (pointing at the private parts), then, they further continue and say “it is yours (pointing to young boys” and then say “ take... take..., take..., while shaking their hips towards the boys. This encourages Tsonga*

*youth to engage in sex while they are still young and with different partners.” (KI 3).*

As part of the tradition, boys and girls attending initiation schools are also involved in singing songs which influence them to become sexually active and to make sure that they get a sexual partner.

*“The songs that they sing when they are at those initiations also have a role that they play in encouraging the boys and the girls into being sexually active or have a sexual partner. And one other thing is that if a boy has multiple girlfriends, he is considered to be a hero “loko a ri na tintombi to tala u tekiwa a ri nhenha, u tekiwa a ri munhu wa vuswikoti”, he is considered to be capable “according to our Tsonga culture. That is all I can say for now.” (KI 17)*

These types of songs encourage engagement into HIV risky sexual activities. Other common HIV risky behaviour related to language is the praises which are offered to men who have multiple concurrent partners.

#### *4.2.1.2.2 Praising multiple-concurrent behaviours of men*

Men are engaged in multiple concurrent relationships for different reasons. The reasons include being migrant labourers (Evian 2011: 407). Some men get engaged in multiple concurrent relationships because of heroism which is embedded in some of the traditional songs. Some songs encourage Tsonga men to have sexual relationship with a widow as there are benefits compared to any other woman as reflected below.

*“When it comes to the songs, I can only think of one song for now. And the lyrics to the song that I remember goes like this “nsati wa ku cinga na wa ku lovola ku wina mani?” and it means that between a widow and a woman who is not a widow, the one who wins is the man who is having a sexual relationship with a widow because the widow has inherited wealth from the late husband. The wealth includes having a kraal of cattle, money, and her cars. The song goes like this (participant sings) “Nsati wa ku cinga na wa ku lovola ku wina mani? Ku wina wa ku cinga, a nga na yini? A nga na xivala xa tihuku na timbhongolo a Fanta ge! (Referring to cold drink Fanta) She wins. So they mean that a woman whose husband is still alive is not considered because she still has to take care of her husband than a widow because she is free and she is able to entice men because*

*she has money and she can do almost everything for men. “U ta ku endlela, wa dyisa kahle-kahle” Wansati wa ku cinga na wa ku lovola ku wina wihi, ku wina lo wa ku dyisa,” (KI 14)*

A key informant explained in the quote below on what the Tsonga songs which expect what a real Tsonga man means. One of the criteria is that a man should have lot of wives. Striving to meet the criteria, men even have multiple partners because they want to conform to the expectation of being called a real man. The following quote was mentioned:

*“And in our Tsonga culture when we say that this is a man “munhu loyi i wanuna loyi” we refer to a man as a real man if he has a lot of cattle, many wives, many children, that man is given the status of being a man “se u vuriwa ndhoda i wanuna, mani na mani loko a n’wi langutile wa n’wi vona kuri loyi a ko va xinuna-nunana I wanuna, I mnumzana”. So a lot of men want to be referred as such, they then have multiple partners because they want to claim the status of being called “real man” and having married lot of women and to prove that this is real, even the surnames have meanings.” (KI 14).*

In the era of HIV, people still practice polygamy, and they are still unfaithful on the other hand. According to van Dyk (2011: 224), it is important to promote loyalty and fidelity to the husband and all wives, and no one should engage in sex outside a polygamous marriage. One participant had this to say:

*“It is because now people get married, they don’t go for testing to check their HIV status and check what is happening; thus the problem. People just marry multiple partners. If the husband is infected with HIV, then it means because he has a pool of women; all of them are going to be infected. And with polygamy, it does not mean that the guy stops cheating (laughter). He is still going to have girlfriends while being married.” (KI 7)*

Unfaithfulness is not only done by men. The following quote illustrates how women can also be involved in extramarital affairs. According to Evian (2011: 406), women may delay consulting for STIs, which may be there but unaware. HIV also ,may be present without symptoms in the body (Mogotlane et al 2014: 362) A participant had said this:

*“And now as a Doctor, I find a lot of women who come to consult with STIs (Sexually Transmitted Infections) and they are confessing that they are cheating on their spouses.” (KI 7)”*

Another expression of language which may have an influence in the management of HIV is the clan names.

#### **4.2.1.3 Clan names**

The Tsonga cultural group has a lot of different clan names. Each clan name has its way of praising. The role of parents and grandparents is to teach all children to master praise of their paternal clan name until they can recite it. During the process of learning all about a clan name, children are being socialized about how to behave in line with a clan name (Mathebula 2013: 20). The themes under this clan names are: Promoting polygamy, Promoting extramarital partners.

##### *Promoting polygamy*

Polygamy, in Tsonga, is called “tshengwe” (Marhanele & Bila 2016: 700). It has been practiced and has been part of the identity for the Tsonga ethnic group (Mathebula 2013: 10). Polygamy is mostly promoted through some clan names making it like a family aspect. The following are excerpts which reveal that some clan names encourage the practice of multiple concurrent partnerships.

*“There are some clan names that we need to look into regarding the way they praise themselves. Allow me to give you an example of three clan names which are also used as surnames of the Tsonga people. For example, the Xirindza surname, they call themselves “va ka munkwana wo tlela enswanyweni, vaka nghala a xi hundzi tshanga” that is a proverb and those are the praises and proverbs that show us that they believe that men cannot just pass women and do nothing about them. They praise themselves by saying that “va nghena endlwini va ri vambirhi, va huma va ri vanharhu.” Literally meaning that they enter the bedroom being two, and when they leave the bedroom, they will be three people. This means that whenever they have sex with women, women should fall pregnant. So we need to understand what they mean by “munkwana yo tlela enswanyweni,”*



*meaning that men's minds are always on women or they see women as their sex objects.”. (KI 17)*

It is evident that there will be a lack of discipline and honesty in men who can apply the praise of their surnames, and there might be in danger of contracting or spreading HIV if they practice unprotected sex. The following is a quote indicating how some men cannot just pass a place where there are women or cannot ensure that they establish a relationship with one, more especially saying that once a man is with a woman behind closed doors, there will be a third person. The following extract suggests that there is no protection during sex as the third person means a woman will have conceived.

*“And when they say “nghala a xi hundzi tshanga,” (a lion cannot pass a kraal with some cattle) you also need to understand what they mean by that. And again you need to understand what made them praise themselves by saying that “va nghena endlwini va ri vammbirhi va huma va ri vanharhu” then you need to look into what was happening.” (KI 17)*

The quote below reflects that some clan praise themselves by boasting regarding their manhood, which is demonstrated by the fact that they need to engage in sexual intercourse to prove what the praise says.

*“Another surname that encourages the spread of HIV is Baloyi because they praise themselves by saying “hi va ka ncila a va ololi, loko wo wu olola wu to tshoveka”, meaning that they believe that their manhood (private part) is working very well, is able to become erect and cannot relax or go back to normal without having sex with a woman (meaning erection cannot be relaxed by using hands).” (KI 17)*

#### *4.2.3.3.2 Promoting sex before marriage*

There are many clan names for the Tsonga people in general; some are big and famous such as Valoyi and Maluleke (Mathebula 2013: 108). The Nkuna clan is also not different from the others, for them it is obvious that men move from one woman to the other while they are sort of testing through sexual intercourse with each woman until he decides this will be the right woman. The following quote reflects an illustration of the praise for the Nkuna clan.

*“For example, the Nkuna surname (clan) they praise themselves by saying “hi vona va ka mavuta a yi twile” meaning that they don't marry a woman and settle down*

*with her without engaging in sexual activities with her before marriage; instead they engage in sexual activities with different women before they can settle down. And by so doing, you are not going to try with one woman. You are going to try and compare, comparing those women and in the end or later after several sexual encounters you then decide to choose amongst all the women the one who is, better, then you marry her. So that is what they mean when they say “u vuta se u yi twile.” (KI 14)*

#### **4.2.3.3.3 Promoting engagement in sexual activities**

The praise of clan names in the Tsonga cultural group has got an influence on how men behave, apart from cultural practices such as polygamy, informants in this study indicated that men defend their behaviour of wanting to prove that they are real men and strong when it comes to sexual matters due to their clan name yet in the process they may be spreading HIV or contracting the virus. One of the informants had the following to say:

*“These are the things that we need to look at in order to understand what all these surnames mean when they are praising themselves; you can also learn what other clan surnames mean because people want to live according to what their surname means and they go out there and spread the HIV because they protect themselves as they say they do exactly what relates to their praise surname. When they say hi va ka masiya yi govile yi govela vurhena. It refers to men that they are strong people when it comes to their manhood.” (KI 17)*

Apart from clan names, Tsonga people have certain aspects which are considered as taboos.

#### **4.2.1.4 Taboos**

A taboo is defined as a social or religious custom placing prohibition or restriction on a particular thing or person (Concise Oxford Dictionary 2011: 1465). According to Tjale and de Villiers (2004: 148), “a taboo is a prohibition or rule associated with people, things, animals or situations and regulates people’s behaviour in specific circumstances that have magico-religious significance.” A similar explanation was found in the Dictionary of Xitsonga language by Marhanele and Bila (2016: 647) defining “swiyila” taboos as

milawu leyi yi yirisaka maendlelo yo karhi” meaning rules which prohibit doing of certain things. The following subthemes emerged under taboos.

#### *4.2.1.4.1 Lack of sexuality education due to Tsonga cultural belief in taboos*

Talking about sex is considered a taboo in Tsonga culture. The following is a quote wherein one key informant explains that children are sometimes not getting correct information because a parent is prohibited from speaking to children about sexual matters as it is regarded as a taboo.

*“What I know is that culturally when one talks to the children as an elder about sexuality issues, it is not considered to be a piece of advice; instead it is considered as a way of encouraging those children to engage in sexual activities. If someone here that you as a parent is talking about sexuality issues with your child, it is considered a real taboo. They even consider that that child who is exposed to that forbidden language, that is what is considered as a taboo, that child is going to end up being abnormal or suffer from sexual disorder or mental illnesses. This makes parents not even to attempt talking about ‘those things with the children due to fear of consequences of being involved in taboo issues.’” (KI 13)*

One of the key informants stated the following quote, which suggests that taboos which restrict or prohibits people from speaking about certain issues such as diseases may fail to disclose a positive HIV status.

*“In my family, it is still a taboo in such a way that when someone has a cough, they start pointing fingers and say that that person has HIV meanwhile they don’t know how I got infected of the HIV. It might happen that I did not contract HIV because I am a lose woman. Instead I am a one-man woman, and because of the stigma, we are not disclosing our status”. (KI 1)*

Besides language-related aspects, Tsonga communities practice certain cultural rituals which might have a negative impact on HIV management.

#### **4.3.2 Rituals**

This theme focuses on rituals practiced by Tsonga people as part of their culture. A ritual refers to a prescribed or established form of religious or another ceremony. It can be a stereotyped activity or behaviour or a procedure that is followed consistently (Concise

Oxford Dictionary 2011: 1295). Tsonga people practice several rituals. The rituals include those for initiation schools, post-death, and for marriage.

#### *4.3.2.1 Initiation Schools in the Tsonga Culture*

Traditional initiation schools are called “ngoma” in Tsonga (Marhanele & Bila 2016: 434). Initiation schools are some of the cultural practices of most African societies. One of the most cultural practices among Tsonga communities is circumcision.

##### *4.3.2.1.1 Male circumcision*

Circumcision among the Tsonga cultural group confirms that one has passed to adulthood (Mathebula 2013: 10). Circumcision is an old practice which has been in existence in many countries globally. It was done for different reasons, such as religious, social and medical. Circumcision is good for reducing the chances of HIV infection by 50% to 60% (van Dyk 2011: 55). There are risks for circumcision such as bleeding and infection. The following indicate issues related to traditional initiation school.

*“When I talk of the physical issues, I am referring to the blades that they are using for circumcision; they are not sterilised. They can be using the new razor blades, but they don’t have anything to sterilise those new razor blades before they can use them. Even if they can use a new razor blade for each initiate, there is still a chance of infections because they are not sterilised compared to the blades that are used by the medical doctors. And the environment in which all these things are done is very much unhygienic as well because there is bleeding that happens to those initiates, and some initiates bleed for two to three days. So you see that even if the person who performed the circumcision has used a new razor blade, there can be nothing to prevent the bleeding afterwards. And the people that will be responsible for the bleeding don’t have gloves that they can use to protect themselves with; the gloves are only used by the traditional doctor who has performed the circumcision. The people who take over from the traditional healer and look after the bleeding don’t use the gloves because they don’t have them. So those are the things.” (KI 16)*

The following is a quote expressing how initiation school can be dangerous at times. This looks at the fact that for initiates who were born HIV positive, some initiates may contract

HIV from such people and beyond the other initiates the initiator, and those who will be caring for the circumcised area of the HIV infected boys may be vulnerable if gloves are not used.

*“And the fourth one that is contributing to the spreading of HIV is when boys go for traditional circumcision when they are cut, only one blade is used for many initiates. Using one blade for many initiates is dangerous because some of the initiates have diseases even though they go for traditional circumcision while they are young, some of them come being HIV infected even though they are still young as they were born HIV positive. So, during that circumcision, some initiates may be infected with HIV.” (KI 14)*

The second challenge is that if there are still initiation schools which use one instrument to circumcise boys, there may be a potential risk of spreading HIV infection right at the initiation school. Young males may find that instead of being “sharpened,” they can find themselves becoming “blunt” due to having contracted infection at the initiation school. The following two quotes reflect on the use of one instrument.

*“When it comes to the male initiates, they are encouraged, they are told that they are preparing them so that they cannot have problems or have challenges when they have sex with women. In other words, there are instruments that are used in the traditional circumcision initiations, for male initiations- circumcision and those instruments need to be looked at to find out how safe people are when those instruments are used on them. The thing is that they don’t use one instrument for one boy and dispose it off; they use the same instrument for many male initiates, and that can contribute towards the spreading of HIV.” (KI 17)*

Another issue associated with activities and procedures that are done to male initiates is that they are being prepared physically and psychologically that by the time they are circumcised they can go ahead with women because they would have been fully prepared for sex (their male sex organ is being sharpened for engaging in sex) without anticipating any problem when engaging in sexual intercourse. The concern is that there are no lessons or take-home message about their role for safe sex. One participant mentioned the following:

*“When it comes to the male initiates, they are encouraged...they are told that they are preparing them so that they cannot have problems or have challenges when they have sex with women “va byeriwa leswaku leswi u endliwaku swona ho ku lota hi endlela leswaku u nga vi na swiphiqo loko uya hlanagana na munhu wa xisati” (KI 17)*

#### **4.3.2.1.2 Female circumcision**

The following quote gives a picture of some of the negative things that are done for girls at the initiation school, such as being influenced to have a boyfriend. Besides, there are secret things that are happening with females for their private parts. Looking at this situation, young girls can become vulnerable to HIV infection due to activities happening at the initiation schools.

*“When it comes to the female initiations, there are some questions or that which is intended to ill-treat the female initiates; they are asked as a way of finding out if they are in a relationship with someone and who that boy is. And if they have found out that she does not have any boyfriend, she is encouraged to choose one boy that will be her boyfriend. Then there are some things that I cannot disclose what is done to the women when they are attending the initiation schools because some of these things are done in their private parts”. (KI 17)*

Apart from initiation schools, the other common rituals are conducted following a death in the family.

#### **4.3.2.2 Post-death rituals**

Tsonga communities practice several rituals after the death of a person in the family. The rituals include practices after death of family members such as Family protection, Cleansing of the widow and Partner inheritance.

##### **4.3.2.2.1 Family Protection**

The traditional practice of most Africans is that there should be some rituals following a death in the family. Unfortunately, some of the procedures involve shaving the heads of every member of the family. The chances of spreading infection in case there is an HIV positive family member is high. The following extract reflects the beliefs of some Tsonga people regarding the need for the house/family to be protected against evil spirits.

*“Then there is also this traditional practice, I just don’t know what they call it, but a traditional healer is invited to the house, and there are some things that they do believe that they are protecting the house/family against the evil spirits. And these things are not done in the open. Instead, the traditional healer will visit the house at night, and each child of the house will have to make a turn to the traditional healer for him to perform the traditional incisions on them. And they are then smeared with traditional medicines, and for that medicine to work; there must be blood.” (KI 12)*

*“What happens in our Tsonga culture is that if there was death in the family, all the children in the family and everyone has to have their hair shaved, and they use one razor blade to shave hair. So, because they are using the same razor blade to shave, accidents happen and sometimes the skin may be cut, and there will be bleeding while they were being shaved; and in that way HIV can spread from one person to another.” (KI 14)*

Though the entire family members are protected, if the person who died is a married man, the widow is also cleansed.

#### *4.3.2.2.2 Cleansing of the Widow*

The Tsonga cultural group also beliefs in cleansing the widow after the death of the husband. During the cleansing process, the women is expected to engage in sexual intercourse without a condom with a man identified as a cleanser.

*“According to our Tsonga cultural practice or the cultural practices of Bushbuckridge, what happens is that maybe I am married, and my husband passes away. When the mourning period is over, as a wife, I have to perform the cleansing rituals to cast away the bad spirits. And the cleansing rituals have to be done by having sex with a man.*

*“Then there is also this Tsonga cultural practice where if a man or a woman has lost their partner and they have to perform the cleansing rituals. There is a time when a widow has to undergo the cleansing ritual, through sexual intercourse with*

*a man for her to be cleansed, so if one of these people is HIV positive; infections will be passed to the other person through the cleansing ritual process.” (K 3)*

Some widows are being exposed to invasive, traumatic procedures performed as ritual following the death of a husband. The following extract explains briefly what is done.

*“Then there is also something that we should take note of, this practice that is done when someone has lost their partner, the elders take that particular person to the river or the stream and they do some brutal things to that woman and in the process the woman can bleed or have wounds in her body.” (K 5)*

The following quote adds to the concerns regarding the cleansing ritual of the widow. What seems to be making this practice more dangerous it is because money is involved. There are men who then become involved in cleansing rituals of widows to make money. Unfortunately, even if their husbands died of HIV related causes, the widow will not disclose to the cleanser.

*“And the other thing that happens is also the practice of cleansing rituals. They don’t care who comes to perform the cleansing rituals; anyone can do it especially nowadays because those people who do it are paid to do the cleansing rituals. Then one cleanser can go all over to do a cleansing ritual. So those people do the cleansing ritual for the sake of getting money, this person is only happy to be paid. Meanwhile, some of the people that they are cleansing are HIV positive, and they don’t tell him what the cause of death was, or they don’t know what killed the person (husband) they are doing the cleansing ritual for. So, in the process, that person (cleanser) can be infected and also infect other people while performing the cleansing rituals. So, these are the practices that we do as the Tsonga people, and they contribute to the spread of HIV”. (KI 7)*

*“You know like a woman who lost her husband following the formal removal of the mourning clothes, and she must go and have sex with somebody for seven days and not use condoms, and unfortunately there are men who specialise in doing that. Many men are being paid for that. So, most of these things happen because it means that these guys then go around, it is their job, and everywhere they go they don’t use condoms.” (KI 7)*



Apart from the cleansing rituals which happens after the death of a spouse, there are issues of partner inheritance.

#### **4.3.2.2.3 Partner Inheritance**

Partner inheritance is one of the cultural practices common among Tsonga people. The family of the man who died makes sure that the widow is inherited by a member of the family irrespective of his marital status. The widow can be vulnerable or may infect the inheritor and wife (wives) if he is already married.

*“Another thing is that when a member of the family has died, there are some cultural practices that the Tsonga people practice. If it is a woman whose husband has died, the family of the deceased have a meeting and decide on who has to inherit the widow since her husband has died and that can also contribute to the spread of HIV. The reason why wife inheritance can contribute towards the spreading of HIV is the fact that they don’t consider whether the man inheriting her is married or not.” (KI 5)*

The following statement confirms that a sibling of a woman who died can be vulnerable because she can be offered to her brother in law as a replacement, similar to being inherited. It is becoming clear that if one of the couples was HIV positive, the woman offered for substitution might be at high risk of contracting HIV.

*“Another thing is where the husband has lost his wife because what they do is to get the female sibling of the late wife or a daughter of her aunt or any other women related to the late wife or in any way that is permissible according to culture and get her to marry the husband. So, it’s obvious that if one of them is HIV positive, HIV will find a way to spread in that way”. (KI 5)*

Apart from death-related rituals, there are other rituals related to marriage, which may also affect the management of HIV and AIDS among Tsonga people.

#### **4.2.3.3 Marriage related rituals**

This theme focuses on rituals which are related to marriage. The theme has the following subthemes: arranged marriage and treatment of infertility.

#### 4.2.3.3.1 Arranged Marriages

Some parents tend to organise marriage for their children for various reasons. The following quote demonstrates how parents arrange marriages for their children: *“Another habit that the Tsonga people have is that when they realize that the family where one of their daughters is married to is wealthy and she is well taken care of, they even talk to the man regarding marrying the wife’s younger sister or any other relative of the wife or a daughter to her aunt because they can see that the man can take care of them all because of his wealth. In the end, that man will have more than one wife and it is clear that if one of them is HIV positive, obviously the others will be infected as well.”* (KI 12)

One of the findings of this research revealed that polygamy is even promoted by the parents of the bride. In the following quote, parents would be happy if their daughter is married by a man who has a lot of cattle as he was regarded to be rich. Some parents would even go to an extent of recommending and encouraging the husband to their daughter to marry the younger sister of their daughter as the wealth of the man gives an impression that they will both receive better care.

*“The Tsonga culture encourages or allows men to marry as many wives as they want. This happens in most cases where that particular man has a lot of cattle or is wealthy because parents believe that their daughter will be well cared for by that particular man because he is capable of taking care of them because he is wealthy. So that is what contributes to the spreading of HIV because if that particular man has three or four wives, and if one of them contracts this virus; the rest of them will possibly be infected as well.”* KI 15)

Apart from an arranged marriage, married couples are expected to have children. If not, they resort to several means of managing infertility.

#### 4.2.2.4.4 Treatment of Infertility in the Tsonga Cultural Way

Infertility is considered a curse among Tsonga people. This makes the elders to ensure that it is prevented by all means. Even if one partner is infertile, the elders will ensure that

that couple ends up having a child. The following is a quote to explain how infertility is managed culturally.

*“The barren woman, those who cannot become pregnant, we usually say when a person is married at least after three months, we must see a change in a woman. She must be pregnant, and if she is not, we start to query now and yet the problem could be the infertile male. We then take this woman because women are the unfortunate ones; they are always blamed for not giving birth. This woman could be taken to a traditional healer, and the traditional healer will assist by all means. Most of the time, the traditional healer usually has sex with the women saying that, the women’s womb is blocked, and for it to be unblocked, the male traditional male healer will have sexual activity with the women in the demise that he has applied the treatment on his private part, and the only way to insert the treatment, is to have sex with the woman. He will then discharge this woman so that she can go home and meet her husband who will believe that he is the one who made her pregnant and yet the man is infertile, so that is that. Sex with a traditional healer.”*  
(KI 13)

In the process of seeking help for the treatment of infertility, women are at times abused by the traditional healer sexually. One key informant said the following:

*Unfortunately, from experience with the patients, some of the female patients get sexually abused by male traditional healers, that is the problem, it is complicated now because it is not a cultural thing, it just happens in the process. (KI 7)*

Apart from rituals practiced by Tsonga people, which may affect management of HIV, this community has their own beliefs regarding the origin of the diseases.

#### **4.3.4. Beliefs About the Origin and Causes of the Diseases**

This superordinate theme focus on the beliefs of Tsonga people regarding the origin of diseases. It is composed of two themes namely: witchcraft and ancestral call.

#### **4.3.3.1 Witchcraft**

According to Tjale and de Villiers (2004:148), witchcraft has been said to be prevalent throughout Southern Africa, causing problems which only a traditional healer can solve them. The findings of this study revealed that there are people who are still convinced that the underlying cause of a person's sickness is witchcraft. Such a position will be seen by health-seeking behaviour of consulting traditional healer. The statement below reflects such perception.

*“They believe that when a person is sick, he has been bewitched, he must be taken to traditional healers to find out who is responsible for killing him” (KI 17)*

Apart from witchcraft, Tsonga people believe that the cause of the sickness maybe from the ancestors or a sign of ancestral call.

#### **4.3.3.2 Ancestral call**

People who believe in ancestors can be convinced that a person can develop an illness because ancestors have the ability and powers to punish a person or send a misfortune if people do not pay attention to their counsel (van Dyk 2012: 217). The following extract portrays a picture of what will make people conclude that ancestors are involved.

*“Another thing is that HIV is associated with the ancestral calling in such a way that when a person is HIV positive, they don't go to the clinic for treatment; instead, they go for sangoma initiations. This happens especially if that particular person is having hallucinations they think that she/he has to go for traditional healer's initiation.” (KI 13)*

Apart from believing that ancestral call is the cause of diseases, some Tsonga people believe that illnesses occur as a result of punishment by ancestors.

#### **4.3.3.3 Punishment by Ancestors**

Ancestors are viewed as central to the lives of Africans (van Dyk 2012:217). Tsonga people believe that ancestors are able to cause illnesses and even death if they are not appeased. This makes other people believe that there is no HIV and AIDS but just problems resulting from the ancestors as a punishment. One of the informants had this to say:

*“I can say that for the Tsonga people, they still don’t believe that HIV exists; it has not sunk in their minds. For us, it is still a matter of the ancestors and TINDZHAKA (Diseases contracted due to failure to follow the cultural practice when there was death in the family). They still believe that it is just a minor ailment that is caused by the ancestors because they have turned their backs on you, something like that.” (KI 1)*

*“His family believed that he had MAFULARA (diseases contracted due to not following the rituals when a member of the family has passed away) and he was taken to the traditional healers and there was nothing I could do to stop them because to them I was just a daughter-in-law and he was their son.” (K 5)*

Based on the above beliefs in relation to the cause of diseases, some of the Tsonga people resort to traditional healing for the treatment of all the diseases.

#### **4.3.4. Traditional Healers**

Tsonga people believe in traditional healers for different reasons. Due to a strong belief of people to traditional medicines; traditional healers seem to be used because of their credibility in the community (van Dyk 2012: 229).

*“There are many people who don’t believe in hospitals. They believe that when a person is sick, he has been bewitched; he must be taken to traditional healers to find out who is responsible for killing him” (KI 13)*

Informants mentioned that, during the process of traditional healing, the most common way of providing medicine is through making an incision on the skin, to let bad blood to go out and also to provide entry for medicine. The following quotes illustrate such a situation.

*“There are many people who don’t believe in hospitals. They believe that when a person is sick, he has been bewitched, he must be taken to traditional healers to find out who is responsible for killing him and he must be given treatment by the traditional healers. Where the majority of them use razor blades to cut to remove the evil blood and also to apply the medicine. After using the razor, they can reuse it for the entire family or other people. (KI 17)*

*“And one of the modes of treatment for traditional healers, it is where they cut and apply traditional medicines, and in the process of cutting, most of them don’t even use gloves. They do it barehanded and now these people you know they can cut themselves” (K1 7)*

*“Because most of these people, have HIV themselves including the traditional healers. they cut and apply some herbs using their fingers on the open wounds, so they can get HIV through the cutting and using their bare hands to apply the medicines on the wounds.” (K1 7)*

Besides trying to cure the existing illnesses, traditional healers also protect family members including children from being bewitched. The practice of believing in the protection of members of a household can put children at risk. The traditional healer may spread or contract HIV. One informant had this to confirm HIV risky practice for a child

*“Each child of the house will have to make a turn to the traditional healer for him to perform the traditional incisions on them and they are then smeared with traditional medicine, and for that medicine, to work, there must be bleeding.” (K1 12)*

*“When a child has sores on the head (muna), the father and the mother should engage in sexual activities and use their discharges to mix with certain herbs and apply on the open sores. The child may be born HIV negative and can be HIV positive because of treating sores on the head”. (Participant 9)*

Some women still prefer to deliver at home instead of the hospital with the assistance of traditional birth attendant.

According to van Dyk (2012:47), the risk of transmitting HIV from mother to child is high during labour and delivery when mother’s blood and mucous come into contact with the baby during birth process. The following quote shows that home delivery can be dangerous.

*“Then there is this one that I don’t know much about, the elderly women, traditional birth attendants (masungukati) I do not know very well how they do it; but it carries*

*a certain danger because it is a practice that is done when they are helping a pregnant woman to deliver the baby. During that delivery process, traditional birth attendant doesn't use western things, they don't use gloves to protect themselves, a woman is being assisted in any way, and there can be an exchange of blood or contact during that process or blood can spill.” (KI 14)*

*” Another thing is home deliveries because these women handle blood without gloves and all those things. There are still a lot of women who deliver at home. I always come across a lot of home deliveries.” (KI 7)*

As in Tsonga culture, HIV is a result of ancestors or witchcraft, even when a person has been put on antiretroviral treatment in hospital, after visiting traditional healers, people usually discontinue the treatment:

*So, you may find that maybe I am HIV positive and I disclose to my family, then they mislead me towards using traditional medicines to treat HIV. And if I agree to use traditional medicines and my partner also use traditional medicines, in my understanding we are not treating the virus. Instead we are making it grow, and it multiplies because of the traditional medicines. So, I think that traditional medicines contribute to the spreading of HIV.” (KI 6)*

*“They advise the HIV positive person to stop using the medicines that they have been given at the clinic so that they can try the traditional medicines. And in that way, the virus will worsen because, by the time that person is using the traditional medicines, you find that they are continuing to have unprotected sex.” (KI 4)*

Besides reliance on traditional healers, Tsonga people, especially women, believe in enhancing their beauty through performing tattoos.

#### **4.3.5 Tattoos**

A tattoo is a picture made on the skin or design on the skin with indelible colours (Concise Oxford Dictionary 2011: 1546). Tattoos have been done by women as a culture for decorating themselves. These tattoos were done on their “chins, arms, legs, and other parts of the body” (Mathebula 2013: 9). Tsonga people, especially women use tattoos to

beautify their face, others even write the names of their partners on the arms or even thighs.

*“There are many Tsonga cultural practices that can contribute to the spreading of HIV, but I have chosen to talk about the following. The one that I want to talk about is the one where people are doing traditional incisions and tattoos (leyi ni ngo I ku tlhavela tinhlanga kumbe swibayana hi Xitsonga vanhu va fanele va bomba). Europeans call these tattoos. For us, in Xitsonga, they are done on the face and some parts of the body. This is where a Tsonga woman who has these tattoos are meant to characterise women, and it was their way of making themselves beautiful and stood out from the other women”. (KI 14)*

#### **4.4 Conclusion**

This chapter presents the results focusing on biographical data and the themes which emerged from data analysis. The results are backed up with excerpts from key informants' transcripts. The results indicate practices and beliefs of Tsonga people in Bushbuckridge, which may have a negative impact on the management of HIV and AIDS. The following chapter focuses on the discussion of findings based on the superordinate themes, themes, and sub-themes in relation to other scientific studies addressing culture and HIV.



## **CHAPTER 5: DISCUSSION OF RESEARCH FINDINGS**

### **5.1 INTRODUCTION**

The previous chapter outlines the results of this study. This chapter focuses on the discussion and interpretation of the findings. The chapter briefly outlines Tsonga cultural practices which may have an impact on the management of HIV and AIDS. The discussion of findings is based on superordinate themes, themes, and sub-themes that emerged from data analysis and in relation to the existing literature.

### **5.2 DISCUSSION BASED ON THE RESEARCH FINDINGS**

The discussion will focus on language, rituals, beliefs related to the origin of diseases, traditional healers, and tattoos as these are the superordinate themes that emerged from analysis of results.

#### **5.2.1 Language**

Language is one of the components of culture (Mogotlane et al. 2014: 22, Vasuthevan & Mthembu 2014: 6). Findings of this study indicate that language is one of the core aspects of expressing culture. The language expression was done in the form of proverbs, songs, clan names, and taboos.

##### **5.2.1.1 Tsonga Proverbs**

Tsonga language include a wide range of “proverbs depicting various aspects of the social and spiritual life of the Tsonga “ (Junod 2010: 9) As part of the language, this study revealed that there are some proverbs which may hinder the management of HIV through involvement in risky sexual activities due to the promotion of multiple-concurrent relationships, discouraging men from expressing emotions and encouraging women to persevere in marriage.

##### **5.2.2.1.1 Promotion of Multiple Concurrent Relationships**

Example of such proverb is “wanuna wa nava l n’hwembe” (Marhanele & Bila 2016: 778), its meaning is that it is permissible for a man to have multiple-partner sexual relationships. Having multiple sexual partners increases the risk of HIV infection (Sovran 2013: 12). In this study participants mentioned several things condoning multiple concurrent

partnership such as “he is doing that because he is a man, even his great grandfather had three wives, or idioms “wanuna l xihloka ha lombisana” a man is like an axe you can borrow each other, or he can spread like a pumpkin plant to show that he is alive he must be a man for people referring to several women, is not regarded as problem in the Tsonga culture.

This is worsened by patriarchy which is a practice in most African cultures (Madiba & Ngwenya 2017: 61) including Tsonga culture as stated in the Tsonga proverb known as “wanuna l nhloko ya muti” (Marhanele & Bila 2016: 445), meaning a married man is the head of the family whatever he does cannot be questioned and “matimba ya wanuna a ma heli” In this study, challenging a Tsonga. man, or asking questions and trying to negotiate for safe sex is associated with suspicion of mistrust to a husband. This suggests that some Tsonga women are not in a good position to exercise their sexual rights. This can result in a situation where women’s husbands may be involved in sexual intercourse with several partners. Thus, they can transmit HIV to their legal wives or stable partners (Buzuidenhout 2013: 237).

The practices of multiple concurrent partners are not unique to Tsonga culture but to many rural South African communities (Madiba & Ngwenya 2017: 56). According to Mogotlane, Hazeli and Mthembu (2007: 40), Zulu people practice what is called “ubusoka” which is encouraging men to have many female sexual partners and for “a real Zulu man to have one woman or lover or one sexual partner is considered as a taboo. This was also portrayed by Jacob Zuma, the former President of South Africa, who had official six wives (Head 2017: 1) Similarly, cultural practice on unfaithfulness and having an extramarital affair because of cultural norms among Venda groups were putting women at risk of Sexually Transmitted Infections (STIs) (Mulaudzi 2005: 33). The presence of STIs can predispose one to HIV infection, especially if there is a raw area on the genitals. Wounds and sores are risk factors for HIV when coming into contact with body fluids such as semen or vaginal secretions (Mogotlane et al. 2014: 347). According to van Dyk (2012: 253), multiple sexual partners can influence the spread of HIV in sub-Saharan Africa, problems such as concurrency in sexual partnerships, extramarital affairs, multiple concurrent partnerships, and polygamy need to be looked into as cultural factors

associated with the spread of HIV/AIDS (Sovran 2013: 4). Concurrent partnerships are the powerful transmitters of HIV which is common in Africa and make both men and women vulnerable to HIV (Rumjee & Daniels 2013: 3; Madiba & Ngwenya 2017: 60). The practice of multiple concurrent partnerships as cultural practices was also recorded in another African state such as Zimbabwe and Kenya (O'Brein & Broom 2013: 591; Ombere, Nyambedha & Bukachi 2015: 1151).

According to Mulaudzi (2005: 331), male promiscuity is a serious challenge which is tolerated due to cultural norms, and this can predispose women to STIs. Women tolerate being in a multiple concurrent relationship or polygamous marriage because of Tsonga proverbs such as “Vukati bya katinga” (Marhanele & Bila 2016: 750) and “vukati va kandza hi mbilu” (Marhanele & Bila 2016: 750), meaning that a woman should persevere regardless of challenges and whatever obstacles in a marriage including coping with difficult circumstances of knowing that a husband has multiple concurrent sexual partners.

However, the same proverbs, when further explained, can be utilised to warn men against practicing HIV sexual risky behaviour and assist in the reduction of spread of HIV. For example, a proverb which says, “wanuna l nhwembe ya nava kambe yi hlangane na vusokoti” (Marhanele & Bila 2016: 778). A pumpkin plant which spreads may come into contact with ants and be destructed. This is a warning to say that while it is possible to spread, there is a possibility of encountering problems. Reducing the number of sexual partners helps in preventing HIV (Evian 2011: 31). Besides the use of proverbs in promoting or discouraging multiple concurrent partners, there are some proverbs which hinder men from expressing their emotions.

#### *5.2.2.1.2 Discouraging Men from Expressing Emotions*

This study revealed that Tsonga culture discourages men from expressing emotions. They are expected to show bravery and perseverance in all the situations. This concurs with Marhanele & Bila (2016: 777) from a Tsonga proverb which says “wanuna i nyimpfu u rilele ndzeni,” meaning that a man should cry inwardly like a sheep. It is part of some culture to discourage men from expressing emotions. Same findings were recorded by Mogotlane et al. (2014: 29) mentioning that in some cultures, a man is not supposed to cry, or else he should cry inwardly, without being noticed by anyone be it there is death

or when experiencing pain. This practice can result in several problems in the era of HIV. People who do not open up and express themselves when they have problems are likely not to seek help even when there is a need, such as having received HIV positive results. According to van Dyk (2012: 283), people who are HIV infected experience severe emotional reactions and also those that are affected by HIV and AIDS. HIV infected persons can go through different stages such as fear, loss, grief, guilt, anger, anxiety, low self-esteem, and depression (van Dyk 2012: 286). According to Mavhandu-Mudzusi (2014:216) there was a need for psychological support of staff and students who were HIV positive. Through expressing their emotions, men who are infected can access help and emotional support from counsellors and their close family members, thus realizing that HIV is manageable. People are encouraged to disclose their status; it is of benefit to reduce stigma, access to medical services (van Dyk 2011: 298). The fact that men are hindered from expressing their emotions, it may hinder them from coping with HIV, which may either lead them to spread HIV, to default taking treatment or to even commit suicide. Tsonga cultural practice of discouraging men not to express themselves emotionally can result in serious consequences such as feelings of anger, depression, or even suicide (Evian 2011: 75). This concurs with the findings by Carter (2018: 1) mentioning that patients who died from suicide had a mean age of 45 years and 80% were men. Other problems that may result in a person suppressing his or her emotions are a breakdown of the relationship with a partner or family, feeling of embarrassment (Evian 2011: 456). HIV and AIDS and several medical problems are situations which require a person to open up to access emotional support and have a chance to express feelings and emotions (Evian 2011: 457).

Disclosure is a step which can benefit an HIV positive person in many ways, which include reducing stigma, accessing medical services, and lifelong ARVs. Openness about positive HIV status can help women to negotiate for safe sexual practices” (van Dyk 2012: 259). According to Sandy and Mavhandu-Mudzusi (2014: 2732), university students and staff who were HIV positive “had a great need for emotional support.” This shows that even males would require counselling for their emotional aspect. According to Mogotlane et al. (2014: 354), counselling sessions are important, especially for men on condom use and to stick to one partner. Other common emotions which warrant opening a discussion

and support are suspicion, mistrust, fear of losing a partner, fear of gossip, and to be stigmatized. These may lead to a lack of support (Mogotlane et al. 2014: 357). It is clear that a person who does not open up will not access counselling for HIV testing, even if testing is accessed failure to open up may hinder a person to be assisted in finding own solutions to problems related to HIV infection (Buzuidenhout 2013: 238).

Failure to express emotions as a Tsonga cultural practice can also result in Tsonga men failing to access medical treatment and may predispose their sexual partners to HIV infection and to be re-infected. HIV can have a negative impact on people and thus affect them psychologically, emotionally, socially, and spiritually (van Dyk 2012: 283). Individuals can experience fear, guilt, anger, depression, shame, blame (Bezuidenhout 2013: 213) anxiety, and hopelessness (Evian 2011: 471). All these feelings warrant counselling and to be supported towards adherence for Anti-Retroviral treatment and to identify solutions to problems (Buzuidenhout 2013: 213, Evian 2011: 455). Unless a person opens up, non-disclosure will result in failure to adopt a positive attitude towards HIV positive status thus become unable to take full responsibility (Evian 2011: 471).

There is a need to send culturally congruent messages in the era of HIV and AIDS (Mogotlane et al. 2014 :21). Harmful Tsonga cultural practices of not expressing emotions which may be communicated to young boys or young men need to be transformed or modified to realign such practices in the era of HIV pandemic. There is a need to empower men and women so that they can fully take charge in the fight against HIV infection. The Tsonga cultural group should create an environment conducive for men and women to deal with cultural practices that can pose a threat to the spread of HIV. Besides proverbs, songs were also identified by informants as one of the cultural expression of language which has a negative impact on the management of HIV and AIDS.

#### **5.2.2.2 Songs**

Results indicate that Tsonga people have a variety of songs that are sung in different occasions. Some of the songs promote and praise engagement into multiple concurrent behaviours while others promoted engagement in sexual activities.

#### 5.2.2.2.1 Praising Multiple Concurrent Behaviours of Men

This study revealed that one of the Tsonga cultural practices of men in Bushbuckridge is that it is acceptable to have concurrent multiple sexual partners, one informant expressed it as “*nsati wa ku cinga na wa ku lovola u lava mani?ni lava wa ku cinga a nga na yini? A nga na xivala.*” This song encourage men to approach specific woman for some benefits. Similar practices were found in America; cultural messages included the expectation of black men to be promiscuous (Harper et al. 2016: 468). African men do practice concurrent multiple sexual partners relationships. A study of sexual behaviour of older adults in South Africa revealed a risky sexual behaviour where two-thirds of the population was having multiple lifetime sex partners (Rosenberg, Gomez-Olive, Rohr, Houle, Chodziwadziwa, Wagner, Kahn, Tollman & Barnighaysen 2017: 12). It was found that cultural factors which play a major role in the high prevalence of HIV in South Africa are the pride for men to have sex with a lot of women and such men are regarded as real men or *Ingakara* which is a risk factor of HIV. Concurrency occurred in South Africa because sex with an extra partner was said to be okay and shows that you are a real man (Kenyon et al. 2015: 883). Some of the songs encourage men to marry more wives and stay with them, e.g., a song which says, take all of them to the kraal because if they are all out, you will compete with the wolves and jackals. Though such songs encourage multiple concurrent partnerships, it also encourages formalised relationship which if well managed and everyone test for HIV before entering into a relationship, HIV can be slightly controlled.

However, during most of the events, the songs used encourage engagement into extramarital relationship resulting in one-night marriage where men created a small house for promoting temporary or permanent relationship (O'Brien & Broom 2013: 541). These “unknown” relationships are more dangerous as there is no boundary. The same finding was reported by Mulaudzi (2005: 330) mentioning that, among the Venda cultural group; it was found that since polygamy is no longer practiced, most men are having relationships with mistresses which makes things difficult in case of tracing contacts for treatment of STIs. STIs are high-risk factors for HIV as their presence facilitates the sexual transmission of HIV, especially when there are raw areas such as an ulcer on genitalia or gonorrhoea (Evian 2011: 24). Apart from praising people who are having multiple

concurrent partners, some songs promote people, including youth to engage in sexual activities.

#### *5.2.2.2 Promoting Engagement into Sexual Activity*

Findings indicate that some of the Tsonga songs promote people to be engaged in sexual relations. The challenge is that, as the songs are usually sung during open community gathering, they are also listened to and sung by young boys and girls. Those songs encourage even young people to engage in sexual relationship without adequate knowledge of precautionary measures. In this study, it was found that the songs that are sung, especially in initiation schools encourage girls and boys in becoming sexually active. A boy who has several girlfriends after initiation is regarded as a hero. As the engagement to sex is initiated by songs, most of the people engaging in those relationships are not even committed to those relationships. This means that a person can engage with anyone at the hit of the moment. The findings concur with Madiba and Ngwenya (2017: 59) mentioning that there are several men who engage in extra-marital relationship. Some men even practice unprotected sex basing the reason for non-condom use to the payment of lobola. Language is also expressed in clan names.

#### **5.2.2.3 Clan Names**

Clan names are very important among Tsonga people. Men are encouraged to engage in sexual activity in many ways. Results indicate that there are common Tsonga clan names which encourage men to be in multiple relationship or polygamous relationships. The clan names highlighted include Nkuna, Ngobeni, Baloyi and Xirindza. Young males grow up being socialized in a manner that they will want to behave according to their praise. Thus, they will want to prove to women that they are capable; unfortunately, in the era of HIV such messages are not communicated with HIV preventive measures. The praise for the Nkuna surname encourages men to engage in sex with different women before they get married (*va vuta va yi twile*, meaning that by the time a man is convinced or satisfied that he can marry he will have engaged in sex with different women, most probably without a condom. This constitutes aculturally influenced risky practice in the era of HIV and result in making women vulnerable to HIV infection. Another clan name is Baloyi, which encourages men that once their private organ is erect, it cannot relax unless

they engage in sexual intercourse (ncila a va ololi) . The Xirindza clan encourages people to praise themselves that they cannot just pass a woman without doing something to her (nghala a xi hundzi tshanga). The chances of engaging in sex with almost every woman in a community can predispose a man to HIV, and the chances to continue spreading HIV infection to others is very high. This is risky and promotes vulnerability of women to HIV infection caused by men. According to Leclerc-Madlala, Simbayi & Cloete (2009: 5), polygamy is practiced in Southern Africa. Men who do not practice polygamy have more sexual partners or use sex workers. Polygamy has been practiced in the Venda culture, but there are people who are against it as it facilitates the spread of infections. Some believed that a man could rotate to his wives and that prevented the spread of infections (Mulaudzi 2005: 330). It is unfortunate now in the era of HIV “if one woman or the man can be infected in a polygamous marriage there is a possibility that the whole family will be infected (Banda & Kunkeyani 2015: 38). Besides the clan names, language is also utilised to identify aspects which are considered as taboos.

#### **5.2.2 4. Taboos**

In this study, taboos were found to be part of the cultural practices of Tsonga group. Several individual informants mentioned that information about sexuality is something not to talk about, it is taboo. Unfortunately, these taboos even affect giving of information in homes since it is regarded as taboo to talk openly about issues of sexuality to children. Even where people are supposed to talk about health issues involving HIV and AIDS, it appears to be a “no go area”. This finding is similar to other cultural groups. According to van Dyk (2012: 182), AIDS education should be done at schools and should be on-going. It is critical that parents, community leaders, and spiritual leaders should contribute to programmes for preventing HIV and AIDS.

In contrast to the Tsonga culture, where it is taboo for parents to speak about sexual matters with children, some parents in Tanzania would communicate confusing or inadequate information such as warning their children not to have multiple partners and not engage in sex, but they would not tell the reason behind (Fehringer et al. 2013: 209). On the other hand, many parents were found not to be open with their children, and they



gave incomplete messages such as warning them not to be involved with men without stating the reason why (Fehringer et al. 2013: 209).

What was good was that some parents warned their children not to have multiple partners due to the risk of HIV if they engage in sex (Fehringer et al. 2013: 209). Unfortunately, some parents in Tanzania failed to speak to their children about multiple partners as they were doing that (Fehringer et al. 2013: 210). Some parents could not talk to their children due to cultural taboos, as they cannot discuss sexual matters with another generation. Except for taboos, some parents were said to be afraid of talking to their children about sexuality issues as they thought children would then be encouraged to have sex. Some children noticed their parents having multiple partners; thus, they were also doing what their parents were doing (Fehringer et al. 2013: 210).

Similar to the Tsonga cultural group, among the Zulu cultural group in South Africa, around Kwa-Zulu Natal province at Msinga, talking about condoms was a taboo (Mogotlane et al. 2007: 42). This even led to disempowering women; they couldn't insist on condom use as it could lead to divorce. Mogotlane et al. (2007: 40) states that it is taboo for a man to have only one woman or sex partner. It is clear that taboos apply across the activities of daily life. These beliefs in taboos exist in different African cultural groups, especially about sexuality and marriage (Afolayan 2004: 200). In this study, amongst the Tsonga cultural group, it was revealed that taboos hinder giving of HIV and AIDS-related information since it is taboo to discuss about sexual matters openly.

In this study, one informant also stated that even when someone has a cough, the family regards discussion about such an issue as taboo. One of the most dangerous things shared was that even when a girl child is raped, she cannot be assisted because this matter cannot be discussed, this is coupled with the fact that if a girl child is raped by her step-father or biological father the mother can be the one to suppress this matter if the whole family is dependent on the very same person who abuses children. This concurs with Bezuidenhout (2013: 58) who states that acts related to rape are underreported for different reasons. If a person is raped, there should be access to post-exposure prophylaxis for HIV prevention within 72 hours (Bezuidenhout 2013: 166). Ideally, it should be within the first two to three hours following sexual exposure (Evian 2011: 428).

There is a danger if rape is not reported due to taboos, this can lead to the spread of HIV in the community if the perpetrator is HIV positive. In the process of forceful intercourse, a victim may sustain laceration on the vagina, perineum, and rectum. HIV infection or STIs can be contracted since it is unlikely that a perpetrator can use a condom (Mogotlane et al. 2014: 270).

In the context of South African sexuality education, silence was found to be one of the cultural issues when educators were communicating sexuality education with learners. This was even associated with taboos, which included not speaking about what is happening when a young boy goes for circumcision. It is taboo to divulge information to any man who did not go to the initiation school and especially for women. The issue of silence is not only associated with taboos, but also with secrecy that should be maintained for not discussing certain cultural practices (De Palma & Francis 2014: 551).

Similarly, in the Tsonga culture, there is a lack of sexuality education. One informant in this study mentioned that this silence is influenced by labeling topics around sexuality issues to be taboo. Also, some parents think that if they can talk about sexual matters, they will be encouraging their children to engage in sexual intercourse as it is not considered to be an advice. This problem of silence also became distinct as experienced by Life Orientation Education educators in South Africa about sexual matters because it is taboo to speak about matters related to sex. Life Orientation teachers also confirmed that African parents do not talk openly about sex. Due to their cultural background, some Tsonga parents are not free to talk about sex. The black culture is usually quite regarding sexuality matters (De Palma & Francis 2014: 554). According to van Dyk (2012: 182), it is important for schools, religious and civic organizations to play their roles in the fight against HIV and AIDS. Children should be empowered through education and skills as a strategy to fight HIV (van Dyk 2012: 182). This suggests that parents should interact openly with their children about sexuality matters and HIV. Parents should be involved in teachings like teachers who should be at ease with HIV and AIDS-related topics included in a curriculum (van Dyk 2012: 183).

## **5.3 RITUALS**

Findings of the study indicated that there are several rituals practiced by Tsonga people, which may have an impact on the management of HIV and AIDS. The rituals among Tsonga communities are embedded to almost all the stages of an individual's life from pre-conception till after death. It is believed that non-performance of the rituals may result in bad luck, illness or even death. The rituals emphasised in this study include initiation schools, post-death, and marriage.

### ***5.3.1 Initiation Schools***

Some rituals are prescribed and have to be carried out at the initiation schools (van Dyk 2012: 223). Initiation schools have been existing for many decades among the Tsonga cultural group. The major ritual performed in the initiation school for males is circumcision. Circumcision has been treated as a sacred practice for young people. It serves as a major step towards adulthood (Mathebula 2013: 10). According to the Tsonga cultural practice, one instrument is used to circumcise several initiates without sterilizing in between. According to van Dyk (2012: 368), HIV can be transmitted through the reuse of contaminated instruments. The Tsonga cultural group believed in initiation similarly to the Venda culture where boys and girls would be taken to Initiation school in the past (Mulaudzi 2005: 328). A similar practice of male circumcision was done in some rural parts of Nigeria. A harmful practice such as using one knife which was simply washed in between patients was done. Unfortunately, even traditional healers may be infected and in turn, infect those coming to be circumcised (Sovran 2013: 3).

In this study even though initiation schools for girls are not happening like before, and initiates are not that open with details of what is taught during initiation, similar to Malawians, young girls from initiation schools in Bushbuckridge are exposed to do activities which introduces them to sex. These include songs they sing and the type of dance in relation to those songs. Some of them are targeted to older males. In Malawi girls who come from initiation schools are encouraged to engage in sex with a man called "fisi" as they were expected to engage in sex (Banda & Kunkeyani 2015: 42). In contrast with the Tsonga cultural group in Bushbuckridge and Malawi, Zambian cultural issues

which were exposing women to HIV were addressed such as testing of “fisi” an elderly man before he could engage in sexual intercourse with a young woman (Moyo & Muller 2011: 8).

Informants indicated that boys and girls are encouraged to be sexually active after the initiation process. Boys are told that the role of circumcision is sharpening of the private part (penis) as a way of preparation for sexual intercourse, and girls are taught how to conduct themselves during intercourse. Girls would be encouraged to have a sexual partner; boys would be encouraged to prove that now they are “real men.” Unfortunately, these lessons do not include special precautions such as the use of condoms or consequences of unprotected sex. This concurs with Sovran (2013: 3) who says *that* initiation rites encouraged a lot of freedom about sexual matters in Africa, and this promotes promiscuity and thus creating vulnerability to HIV. According to Rumjee and Daniels (2013: 4), engaging in sex at an early age is risky, and there is a “correlation between having sex at an early age and the incidence of HIV.” Tsonga young girls and boys can be at risk of HIV, STIs, and other problems if they start to be sexually active at a very young age. Apart from initiation schools, there are certain rituals which are performed after the death of a family member.

### **5.3.2 Rituals After the Death of a Family Member**

Findings of this study indicate that Tsonga people perform certain rituals following the death of family members. In the Venda culture, death also includes abortion (Mulaudzi 2005: 334). One of the rituals performed after death in the family is that all family members must have their hair shaved, including children using the same razor blade. This could be risky as there may be a potential of spreading HIV in case there can be accidental cuts of the scalp. Contaminated instruments that are re-used without adequate disinfection can lead to transmission of HIV (Evian 2011: 25; van Dyk 2012: 368; Mogotlane et al. 2014: 347). During this process, accidental cuts may happen, causing bleeding in that way HIV can spread between same family members.

One of the informants indicated that rituals about death include unhygienic and unhealthy practices such as preparing tea with water that is mixed with semen and vaginal fluid. This is done immediately after wiping genitals following engaging in sexual intercourse. Another way is that after the burial, the youngest child in the family should engage in sexual intercourse and wash hands in the container of water which is going to be used for preparing tea for the whole family. People in that family should be served with that tea. In the era of HIV, there is a possibility of contaminating water with HIV infected semen or vaginal secretions. According to van Dyk (2012: 368), vaginal secretions and semen are equally risky in the same way as infected blood. Secondly, it is unhygienic to use water where someone has washed hands following sexual intercourse and directly touching semen or vaginal secretions. According to van Dyk (2012: 368) information from the Center for Disease Control in America specify that it is very important to take universal precautionary measures when handling body fluids such as semen and vaginal fluids, and the use of gloves is recommended

However, not all the rituals performed increase the risk of spreading HIV. There are some rituals which may be promoted as they encourage abstinence from sexual activities and other HIV risk behaviours, such as taking alcohol. For example, after the death of family member, or even a traditional leader, in the past people were prohibited from drinking beer and engaging in sexual activities (Mathebula 2013: 98).

Though there are general rituals performed to all family members following a death in the family, there are specific rituals performed by the widows such as cleansing. In this study, the Tsonga cultural practice of widow cleansing is highly practiced in Bushbuckridge. It has been mentioned by almost every key informant in this study. The widow cleaning involves engaging in sexual intercourse with another man. This practice has even taken another form. The cleanser (man) has to be paid a certain amount to engage in sexual intercourse with a widow without a condom for seven days in succession as a cleansing ritual following the death of her husband to complete mourning period. There are men who are known in the villages or in certain areas of Bushbuckridge who are good in performing cleansing ritual. Similar practices of payment of cleanser are performed in

Zambia where in addition to the cleansing of widows, the cleanser even cleanses young unmarried women who lose their parents or child (Muller & Moyo 2011: 7).

This practice is one of the behaviours which increase the risk for HIV infection. Almost 19.6 million people died in Sub-Saharan Africa due to cleansing ritual practices (Muller & Moyo 2011: 7). Most, unfortunately, it is said cleansing ritual is a procedure which is performed without the use of a condom. Unprotected sexual intercourse is the most common way of HIV transmission (Mogotlane et al. 2014: 34). In this study, the seven days continuously increases HIV risk especially when there is inflammation genital area.

Cleansing ritual for a widow is a cultural practice which is done in most African countries (Sovran 2013: 6). In Sub Saharan Africa, sexual cleansing rituals are done, and this can pose a serious risk for those doing it (Muller & Moyo 2011: 7). It is believed that sexual cleansing help to chase away the spirit of a late husband, thus prevents misfortune for those that are living. In Kenya, a sexual cleanser is hired to do cleansing ritual to the widow (Sovran 2013: 6), which is similar to the Tsonga cultural group in Bushbuckridge, widows pay money for a sexual cleanser Similarly, for the Venda culture it is important for a widow to undergo cleansing ritual before they can resume sexual contact.

Men can also be at risk when cleansing a widow sexually (Mulaudzi 2005: 263). One informant even mentioned that for most of those widows, the cause of death of their husbands is not known they might have died of HIV and AIDS-related diseases. Unfortunately, since the cleansing ritual is done by people who believe in deep cultural practices, there is no testing for HIV by the cleanser and widow before the ritual of sexual cleansing. The risk of HIV infection can be more likely in men who specialize in cleansing ritual as it is alleged that some of the husbands have died of HIV related problems. In this study, informants confirmed that even mentally disabled men are used for cleansing rituals. In Zambia, the cleanser would smell alcohol, looks skinny but would freely become the first person to queue for food (Muller & Moyo 2011: 7). What is worse is that if a man is doing cleansing ritual and is known in the community for doing this job he is being approached as he is the first preference to perform the ritual at a specific area without using a condom and he might be a slow progressor being active and well thus spreading HIV infection in the community (Evian 2011:14). Most HIV infected people remain

asymptomatic in the primary phase (van Dyk 2012: 264). This means cleansers can spread HIV if they don't practice safe sex. Besides widow cleansing, there is an issue of partner inheritance, which is one of the cultural practices of Tsonga people.

In this study, partner inheritance or wife inheritance was mentioned as one of the riskiest Tsonga cultural practice predisposing women to HIV. After the death of a husband, a woman should be inherited. An informant mentioned that according to the Tsonga culture, it is acceptable to marry one of his living brothers. In most instances, the family of the husband hold a meeting to discuss and agree on a specific man (from the husband's family) who will inherit her. According to the Tsonga culture, this woman does not have a right to be married outside the husband's family. Widow inheritance among the Luo in Kenya was done by a man from her husband's family or by a professional inheritor. A widow could change an inheritor if she does not belong to her husband's clan. In some instances, a widow could do away with an inheritor if he is not helpful for other basic needs. Similar to the Tsonga culture some widows among Lou in Kenya could get married to a man who will welcome her and become involved in sexual intercourse for some days then leave (Perry et al. 2014: 6). These are situations which can cause a woman to be involved in sexual relationships with inheritors; this creates high chances of contracting HIV. Amongst the Samburu women, a widow is inherited by someone from her husband's clan, and she does not have the freedom to marry outside her husband's family, and she can be vulnerable to HIV (Wanyoike 2011: 195; Muller & Moyo 2011: 7).

Another Tsonga custom involves the replacement of a deceased wife. One informant mentioned that if a husband has lost a wife, a female sibling of the late wife or a daughter of her aunt's daughter or any other relative of the late wife can be organised to marry the husband. This suggests that infection can spread in case she died of HIV or the new wife can infect the husband leading to orphans due to HIV. Even in the Tsonga culture, this practice of cleansing ritual and wife inheritance is done without HIV test and condoms are not used. In Zambia, similar to the Tsonga culture it is required of a widow to undergo sexual cleansing ritual before a man can inherit her from her husband's family (Muller & Moyo 2011: 7).

In the Sub-Saharan countries, in countries such as Uganda, wife inheritance is still practiced (Sovran 2013: 6). This practice has the potential to spread HIV if there are widows of a polygamous man; if the cleanser is HIV positive, he can even spread the virus within the same night (Sovran 2013: 6). In the Tsonga culture, wife inheritance may be done, especially where the widow is still expected to give birth. A brother of the late husband will inherit her, and there is no checking of HIV status even for the wife or wives of the inheritor. If the husband died of HIV, the widow may spread the infection to the family of her husband's brother as she should not use a condom to fall pregnant. Around the rural area of Kwa-Zulu Natal in Msinga, widow inheritance called "ukengena" is a custom, a brother of the late husband should continue with a sexual relationship with the widow so that she can bear children. The widow cannot exercise the right to refuse to be inherited (Mogotlane et al. 2007:40). Vital rights of a woman are transferred from her father to her husband and family (Afolayan 2004: 183). According to Afolayan (2004: 185), when a husband dies, it is not the end of a marriage; it is in the culture and customs of some black South Africans that a close relative or a brother, paternal nephew or a son by another woman should take over full responsibility through widow inheritance. Similar to the Zulu culture, Luo, Uganda, and most Tsonga women are unable to resist cleansing rituals and wife inheritance. These make them vulnerable to HIV since they are obliged to do so culturally.

As this is a cultural ritual which people are expected culturally to adhere to, there is a need for development of HIV prevention strategies (Perry et al. 2014: 1). In Sub-Saharan Africa in Malawi similar to the Tsonga culture, wife inheritance is practiced (Banda & Kunkeyani 2015: 34-47). However, before wife inheritance, the inheritor and the inherited to-be having to undergo HIV testing. If HIV testing is not done, or if one of the two is HIV positive, the man who inherits the women would only provide material resources and not engage in sexual intercourse.

Besides activities related to death, there are marriage-related rituals which also have an impact on the management of HIV and AIDS.



### **5.3.3 Marriage-Related Rituals**

The issue of having children is very important for many married African couples, in particular women (van Dyk 2012: 224). Concurring with van Dyk (2012: 224), children are said to be of special value to African men and women (Muller & Moyo 2009: 8). For people in South Africa marriage “is the key institution around which the social structure revolves” (Afolayan 2004: 181). The most fundamental function of marriage is to produce children. Other things are the sexual expression, physical intimacy, comfort, and to meet social partnership (Afolayan 2004: 181). Findings of this study have shown different aspects related to marriage that can have negative impact on the management of HIV and AIDS. The issues highlighted are arranged marriages and treatment of infertility.

#### **5.3.4.2 Arranged Marriage**

Arranged marriage in the Tsonga culture is promoted. Marriage in the Tsonga culture is usually initiated by parents. Sometimes parents encourage polygamous marriage for their children up to an extent of allowing sisters to be married by one man. Findings of this study highlight that, if parents appreciate what is done by their son in law for their married daughter especially if he is wealthy, they can recommend that their other daughter joins her sister especially if the man has wealth. This arrangement is made without knowing the HIV status of their son in law.

On the other hand, the sister and her husband do not know the HIV status of the wife joining the polygamous marriage. Arranged marriage can be a problem if HIV status of all in the marriage is not known. If the husband is unfaithful, daughters of the same family can be infected by the same husband.

The other type of arranged marriage in the Tsonga culture is when a wife cannot conceive, so parents will recommend her younger sister so that she can bear children for the family. In the process of trying to fall pregnant, she can contract HIV since condoms could not be used while trying to conceive (van Dyk 2012: 225). Arranged marriages can only be safe if there is continuous testing for HIV of all partners. It was confirmed that this could be done in a situation where a woman recommends her younger sister to come and be the second wife. This is called “hlantswa” meaning a young lady who is married by the same husband with her sister or her aunt (Marhanele & Bila 2016: 156).

In this study, arranged marriages were also reported to be done in Mozambique where men from Bushbuckridge go and organise a woman to come and get married to a Tsonga man. This is because it is easy, and some communities in Mozambique are poverty-stricken. Poverty is one of the contributory factors spreading HIV in communities (Nxumalo 2014: 32; Evian 2011: 32; Bezuidenhout 2013: 235; Mogotlane et al. 2014: 364). As one of the purposes of being married is to have children. Infertility is considered a big issue which needs to be treated/ or be kept as a secret at all cost.

#### ***5.3.4.3 Treatment of Infertility***

Similar to other African cultural groups, it was found that in the Tsonga culture, a woman should bear children, especially following marriage. One informant mentioned that it is not acceptable for a married woman to stay for years without bearing children. She is expected to become pregnant at least in three months. In case a married woman cannot fall pregnant, the family can decide to take this woman to a traditional healer for some treatment. Unfortunately, the study revealed that some traditional healers then take advantage of this situation and engage in sexual intercourse under the umbrella of treating an infertile woman through applying treatment onto his private part then introduce it to the woman vaginally. It is clear that the sexual rights of a barren woman are violated as she has to engage in sex with a traditional male healer without her consent, and usually no condom is used since in the process of treating her the intention is to help her fall pregnant but in the process she may contract HIV as the male traditional healer may be doing that to several women who present with infertility. According to van Dyk (2012: 225), an uninfected woman can contract HIV when trying to conceive a baby.

Unfortunately, in the era of HIV if this healer or maybe, his wife or wives can be HIV infected the virus will spread to the innocent woman who engaged in sex to fall pregnant who can also spread HIV to her husband. In a study among Zambians, a woman confirmed that she contracted HIV due to following older people who advised her to solve her problem of not conceiving by allowing her to sleep with another man (Muller & Moyo 2011:4). Similar to the Tsonga culture, in Zambia, for a woman who cannot conceive from her husband, someone is organised to sleep with her until she becomes pregnant (Muller & Moyo 2011: 3). Looking at the issue of engaging in sex until someone conceives that

in itself says possibly several encounters, even one sexual encounter carries a high risk of HIV infection. In Malawi, a man who has to help an infertile woman to conceive and to do the cleansing ritual of a widow is called “Fisi”, which means Hyena (Banda & Nkukeyani 2015: 36). He can spread HIV as condoms are not used. According to Evian (2011: 307), HIV can be transmitted through unsafe sexual practices, women are more vulnerable to HIV than men due to biological, cultural and social factors (Evian 2011: 405, Bezuidenhout 2013: 234). “A woman is a receptive partner during sex”. It is possible to receive Infected semen which can remain in the vagina for some time making the entrance of the virus easy into the body (Evian 2011: 405).

Childbearing in African culture is so important that if a woman is barren, her sister or another woman from her family can be organised to come and conceive with her sister’s husband to bear children who will address the barren woman as a mother (Afolayan 2004: 184). Having a lot of children and many wives was said to be a pride among the Tsonga cultural group as stated by one of the key informants, the man is regarded as “*ndhoda*”. (Kenyon et al. 2015: 880). Thus, the younger sister would come and help bear children. The woman who comes to bear children and the couple’s HIV status is not checked before joining the family. If one of them is infected there can even be Mother to Child Transmission which can occur during unsafe sexual intercourse, pregnancy, childbirth and breastfeeding (van Dyk 2012: 247; Evian 2011: 307).

Findings of this study where every means are done to ensure that there is a child for married couples concur with Muller and Moyo (2011: 1), stating that childbearing has a lot of meaning for everyone, African Americans, and Latinos value children, and it is also proof for manhood or womanhood. This suggests that people can do all sorts of things, even risky steps just to show that they are socially productive.

In this study, one risky, scary thing was that to treat infertility some male traditional healer claim that they should introduce herbs using their private part into the woman’s genital organ because the womb is blocked. This suggests that he may contract HIV or transmit HIV as a condom is not used when he is introducing such herbs, and the innocent woman should keep this as a secret. Thus infertility in the Tsonga culture is a serious problem to

be attended by trying all avenues even if now they pose a risk of contracting HIV. When the child is born, Tsonga people ensure that that child is protected.

#### **5.3.3.2 Child Protection**

In this study, an informant mentioned that in the Tsonga culture, children must be protected from all types of evil spirits, childhood illnesses, and witchcraft. The protection is usually done by the traditional healer who will perform some incisions and apply medicine on the bleeding area. This may be risky as instruments are not sterilized. In addition, there may be a transmission of HIV among children. Informant added that the traditional healer might accidentally sustain a cut and thus transmit HIV to the baby or child through his/her HIV infected blood as gloves are not usually used. Recommended precautionary measures include the use of gloves and plastic apron when doing surgical procedures (Evian 2011: 448 ).

This practice of child protection is similar to the Swazi culture where a mother in law gives traditional herbs and traditional medicine called “*timbita*” to a pregnant woman for protection of the baby from illness and evil spirits before birth. In addition, certain rituals are done to ensure that the baby is immunized traditionally for growth until one becomes a strong adult (Nxumalo 2014: 32). This suggests that some Tsonga people, similar to the Swazi culture, are still not convinced that immunization program from the clinic or hospital is adequate to protect the baby. One informant stated that children can be HIV infected if a mixture of semen and vaginal secretions from parents are used to treat sores on the head called “muna” In the era of HIV, some babies will even miss Antiretroviral drugs which are supposed to be given at birth. Moreover, this study revealed that there are still a lot of home deliveries in Bushbuckridge. The main contributory factor of Child mortality in South Africa is HIV and AIDS; this is associated with poor utilization of Prevention of Mother to Child Transmission (PMTCT) of HIV (van Dyk 2012: 246). These beliefs and practices can be HIV risky for children .The issue of child protection is linked to the beliefs of Tsonga people with the origin of diseases..

#### **5.4 Beliefs About the Origin Diseases**

The study indicates that Tsonga people have diverse beliefs regarding the causes and origin of diseases. The most commonly believed origin is witchcraft, ancestral call, and punishment by ancestors. In this study, informants mentioned that there is a believe that people become sick of HIV related conditions when they are bewitched. This concurs with Nxumalo (2014: 33) who says that the long battle of HIVAIDS in Swaziland was caused by among other things, believe that the underlying cause of HIV/AIDS deaths is associated with witchcraft. Witchcraft is something Africans believe is happening and causing misfortune or harm to people. Africans such as Nguni, Sotho, Venda believe that a person can be harmed by someone who uses invisible spirit. A person can develop an “explicable condition when bewitched, and it is only a traditional healer who can help with herbs (Tjale & de Villiers 2004: 148). In this study, it was revealed that there are people who believe that sickness comes as a result of witchcraft. Many people in the African perspective believe that the cause of the illness is witchcraft. Similar to some Zimbabweans, who believed that witchcraft exists with some family members identified as the underlying cause of HIV related health problems and ancestors (O’Brein & Broom 2013: 539). Some Tsonga people have similar beliefs to Swazi, who blamed witchcraft for HIV related death (Nxumalo 2014: 33). Experience of Primary Health Care nurses is that the belief in witchcraft contribute to delay in consultation as people start at a traditional healer (Baloyi 2009: 134) and later go to a clinic. This hindered service delivery in Limpopo to a certain extent and sometimes seriously. Services for HIV testing are available at clinics; HIV infected patients can spread HIV. Unless a traditional healer refers people to a clinic their HIV status can remain unknown (Baloyi 2009: 126). Cultural issues were said to be a hindrance for service delivery to a certain extent (Baloyi 2009: 133).

Some key informants believe that when a person is sick, ancestors are communicating that they are angry because of a certain ritual that has not been done. This finding concurs with McClellan (2012: 36). In this study, it was revealed that some people when they have an illness presenting with hallucinations being HIV positive it is believed that it is caused by ancestors and it means they have turned their back on you. These people delay to go

and consult at a clinic because of issues of ancestral call, which can only be attended by traditional healers. Van Dyk (2012: 218) reported that almost 8% of people in rural areas associate cause of illness with ancestors. This concurs with van Dyk (2012: 217) mentioning that people who believe in ancestors trust that they can be protected, but they can be punished by ancestors who can send illness and misfortune. People's beliefs in the origin of diseases determines the approach to the treatment. For some of the Tsonga community, most of their treatment is provided by THP.

## **5. 5 Traditional Healers**

Findings of this study show that most of Tsonga people consult traditional healers when they are sick. In South Africa, traditional healers are even formally consulted following Act 35 of 2004 Traditional Health Practitioners (THP) which "provide for the registration, training, and practices of THP in the Republic" (Setwe, Naude & Zungu 2011: 232). In line with this belief, there are traditional healers who claim that they can cure HIV in Bushbuckridge (Audet et al. 2017: 3). Some informants mentioned that some patients consult traditional healers for HIV and other opportunistic infections. Africans have their understanding when it comes to the origin of illnesses.

Some people visit a traditional healer when they are sick to understand the origin of the disease. The cause of the illness is identified through the use of bones to read messages from ancestors who want certain rituals to be performed, or the disease may be a result of witchcraft (McClellan 2012: 36). In this study, it was found that the fight against HIV is still hindered by the fact that people still convince those that are infected about traditional medicine. A lot of people consult traditional healers as it is believed that they can diagnose the cause which is likely to be witchcraft and prevent its recurrence (van Dyk 2012: 218). In Bushbuckridge there are traditional healers who continue to treat for HIV infection and opportunistic infections (Audet et al 2017: 4). One other finding was the Tsonga cultural practice of inviting a traditional healer to do procedures believed to be protecting the family. The traditional healer is invited to the household; traditional incisions are performed using one razor blade where parents and all children undergo traditional cuts (incisions) using the same razor blade, one person after the other at the same time. This practice is similar to the Swazi culture where a traditional healer is invited to visit their

families to perform rituals to all family members so that there is protection from illness and other evil spirits (Nxumalo 2014: 33). This Tsonga practice can put family members at high risk and can be detrimental to the family, especially children who are not sexually active. Should there be a parent who is HIV positive, their children can contract HIV. One informant explained that the traditional healer ensures that the cut is deep enough to cause bleeding so that traditional medicine can be rubbed onto the incision. In this study, it was revealed that except for not changing razor blade, traditional healers do not have gloves to change in between members of the family. With the possibility of accidental cuts as explained by one informant on the fingers or hand of female traditional healers which might have open skin, traditional healers may contract HIV from family members. This suggests that as they use their bare hands, through their fingers to rub in medicine into the freshly bleeding laceration, the traditional healer can become infected through those accidental cuts into the fingers and the fresh blood from the members of the family. The same family has parents who are sexually active and children who may not be sexually active by the time the process of protection is done they may contract HIV from parents or if one child is practicing unprotected sex. This procedure is not a once-off thing like immunization but can be repeated several times as long as the parents deem it necessary, such as once per year.

The approach used by some traditional healers to cure diseases involves cutting of the skin using razor. In this study, Tsonga traditional healers usually perform some traditional incisions using one instrument. The practice of using one instrument can be dangerous (Mogotlane et al. 2014: 347). Also, traditional healer can sustain accidental cuts thus become infected or infect other clients. According to Audet et al. (2017: 4), “the use of razors to inject herbs under the skin of patients” was a worrying factor as there was a risk for HIV transmission from the patient to the traditional healer. Based on the findings of this study, this means the problem needs urgent attention to curb the spread of HIV among the Tsonga community of Bushbuckridge who believe in traditional healers strongly. This concurs with Baloyi (2009: 134) who found that one of the problems that hindered service delivery in Limpopo was that patients saw traditional healers before they went to the clinic, some Primary Health Care (PHC) nurses felt this problem hindered PHC service to a certain extent. People consult traditional healers before biomedicine.

Also, some PHC nurses felt that cultural issues seriously hindered service delivery (Baloyi 2009: 133). What was good was that PHC nurses in Limpopo knew that traditional healers have a role to play in a health team (Baloyi 2009: 126). This concurs with Nxumalo (2014: 33) who says to fight the long battle against HIV/AIDS in Swaziland Traditional authorities have a significant role to play. According to van Dyk (2012: 230), traditional healers will play an important role in the care and support of AIDS patients.

Findings further indicate that people who consult traditional medicines are compelled to stop using antiretroviral treatments. In this study, an informant mentioned that a Tsonga man was made to stop taking ARVs received from the clinic by some family members as they believe in traditional medicine. This man continued to engage in unprotected sex. This informant confirmed that the family believed that he had “mafulara” a disease suffered due to not following the rituals when a member of the family has passed on. He was taken to a traditional healer, and the woman had no say. They don’t believe that he had HIV signs. HIV can continue to spread since a newly infected person is highly infectious (Evian 2011: 41).

Unfortunately, even those who have knowledge are sometimes compelled by members of their families to discontinue treatment. ARVs have been proved to be effective when taken without defaulting. The other problem is that one can develop resistance. Once a person starts ARVs, this treatment must be taken lifelong (Mogotlane et al. 2014: 368; Evian 2011:150).

Even though some traditional healers caused problems in the provision of quality health care (Baloyi 2009: 126), if prevention programmes have to be successful in Africa, traditional beliefs and customs have to be understood, and no AIDS programme can be successful unless traditional healers can help through influencing change in communities (van Dyk 2012: 229). Bushbuckridge community needs such intervention since some Tsonga people still believe in traditional healers who continue to treat HIV infected patients (Audet et al. 2017: 5). It is possible to involve them as others do refer patients to hospital (Audet et al. 2017: 4). Besides the use of traditional healing, Tsonga people, have tattoos which are also part of cultural practices, especially for women.



### **5.3.5 Tattoos**

In this study, one of the cultural practices was performing of tattoos by women for decorating themselves on the face and some parts of the body. One informant stated that Tsonga people, especially women they do tattoos on their faces and some parts of their bodies which characterize a woman, this made them stand out and enhanced their beauty. According to Mathebula (2013: 9), tattoos were done by females as an identity on their chins, arms, and other parts of their bodies. This practice can put women at risk, as there are no precautionary measures. Sharing of instruments and needles to perform tattoos or traditional markings can be risky for HIV infection (Evian 2011: 230). Unfortunately, in the era of HIV, any invasive procedure such as the use of needles must be done with precautions. A needle must not be used to more than one patient (van Dyk 2012: 375). It is risky to share needles or instruments due to the presence of infected blood (Evian 2011: 25).

### **5.7 CONCLUSION**

In this chapter, the Tsonga cultural practices and beliefs such as language, rituals, beliefs related to the origin of diseases, traditional healers and tattoos were discussed in relation to their negative impact towards the management of HIV and AIDS. The discussion indicated how those aspects promote the spread of HIV and also what can be done to reduce the risk of HIV to promote management of HIV. The discussion was done in relation to the existing literature. The next chapter focuses on the cultural approach model to address cultural practices and beliefs affecting HIV and AIDS management among Tsonga people in Bushbuckridge.

## **CHAPTER 6: A CULTURAL APPROACH MODEL FOR MANAGEMENT OF HIV AND AIDS AMONG THE TSONGA PEOPLE**

### **6.1 INTRODUCTION**

A full outline of the details regarding research findings was described in the previous chapter. The findings of the study revealed a wide range of HIV risky cultural practices among the Tsonga people of Bushbuckridge, which may affect the management of HIV and AIDS among Tsonga people in Bushbuckridge. The Tsonga cultural practices and beliefs identified include language, rituals, beliefs related to the origin of diseases, traditional healers and tattoos. The findings indicated that language use in the form of songs, proverbs, clan names, and taboos could fuel the spread of HIV. Similarly, those forms of language can also be used to enhance the management of HIV. The findings also indicate that Tsonga people perform certain rituals such as circumcision. Male circumcision is believed to reduce the transmission of HIV. However, the process in which the procedure of circumcision is performed among Tsonga culture may end up fueling the transmission of HIV. Other rituals identified were the ones performed when there is death of family member or relative. These rituals also have a negative impact on the management of HIV. Treatment of infertility culturally, among Tsonga women poses the risk of HIV infection because of the approach used. Apart from rituals, Tsonga people in Bushbuckridge have diverse beliefs about the origin of diseases. The belief is that all the diseases are the result of witchcraft or from ancestors. This belief determines the approach they seek for the management of the diseases. The findings indicated that some Tsonga people in Bushbuckridge rely mostly on the traditional healers for protection against diseases, identifying the origin and cause of diseases and curing the diseases. The process used to achieve the above involves certain procedures such as cutting, unprotected sex, and discontinuation of antiretroviral treatment which negatively affect the management of HIV and AIDS. Besides the aspects of illnesses, findings indicate the aspects of tattoos which are performed to enhance the beauty, especially for women. The process of making tattoos seems to be having risk for transmitting HIV. All the above aspects have an impact on the management of HIV and AIDS. This chapter provides an overview, description, the purpose, and the structure of the contextual cultural approach

model for management of HIV and AIDS among the Tsonga people. It also provides the process followed to evaluate the model.

## **6.2 DESCRIPTION OF CULTURAL APPROACH MODEL FOR MANAGEMENT OF HIV AND AIDS AMONG THE TSONGA PEOPLE IN BUSHBUCKRIDGE.**

The cultural approach model for management of HIV and AIDS among the Tsonga people in Bushbuckridge was developed based on the findings of this study, identified gaps in the literature, the recommendations from previous literature and suggestions from the informants. The model forms part of phase two of the research and is based on objective two of the study which is: *To develop a contextual cultural approach model for HIV and AIDS management for Tsonga people in Bushbuckridge*. Leininger theory of Culture Care Diversity and Universality focuses on the provision of culturally congruent, competent, and safe care. The use of the theory guided the researcher in identifying culturally congruent approaches of addressing the HIV risks related to language, rituals, traditional healing and tattoos identified in this study and other relevant literature sources.

## **6.3 PURPOSE OF THE SUPPORT MODEL**

The purpose of the cultural approach model is to enhance the management of HIV and AIDS among the Tsonga people in Bushbuckridge.

## **6.4 STRUCTURE OF THE MODEL**

The researcher used the elements of CIPO model to organise the structure of the cultural approach model for management of HIV and AIDS among the Tsonga people in Bushbuckridge. The CIPO is a model which has been developed by Scheerens (1990) to be used as a tool in any educational situation to structure teaching. The model is also used as a framework to analyse the quality of education. The CIPO model has four interdependent components, namely: Context, Input, Process, and Outcomes.

### **6.4 1 Context of the Model**

Bruce and Klopper (2010: 101) define context as a specific set of properties pertaining to a phenomenon and a particular set of circumstances within which an action takes place. The context includes social, cultural, and environmental factors influencing the

management of HIV and AIDS. The context for a cultural approach model for management of HIV and AIDS has the following three levels: Global, national and local.

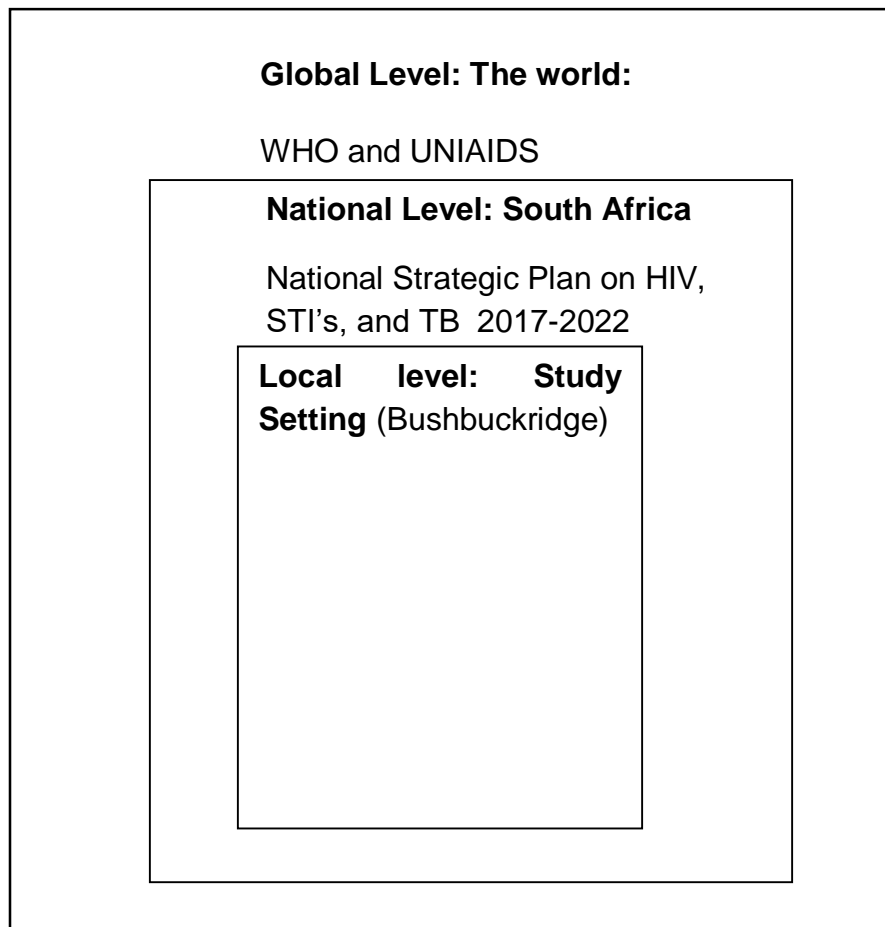


Figure 6.1: The context of a cultural approach model for HIV and AIDS management among the Tsonga people.

#### **6.4.1.1 Global Context**

At the global level, the cultural approach model is guided by the World Health Organisation and UNAIDS guidelines on management of HIV and AIDS. According to UNAIDS (2016), it is important to achieve zero new HIV infections. The groundbreaking vision for Global agenda is Zero new HIV infection, Zero discrimination, and Zero AIDS-related deaths (UNAIDS 2016: 8). According to UNAIDS (2016: 46), communities must revolutionize HIV prevention to achieve Zero new HIV infections. It is critical that young people must be empowered as change agents for activating communities to redress

harmful sexual norms governing sexuality (UNAIDS 2016: 35). There should be programmatic gap analysis and mapping of risks vulnerability to HIV to bridge the gap of knowledge (UNAIDS 2016: 35). This model concurs with UNAIDS as its implementation will help to redress numerous HIV risky Tsonga cultural practices based on the findings of this study thus bridge the knowledge gap and advance preventive measures with specific reference to culture and HIV. The WHO and UNAIDS guidelines lay foundation to national context.

#### **6.4.1.2 National Context**

At the national level, the model is guided by National Strategic Plan on HIV, STI's, and TB 2017-2022. National Strategic Plan goal number four (4) states that "The social and structural drivers of HIV should be addressed through the application of objective 4.1. This can be through the implementation of programmes which can influence behaviour change, reduce risky behaviour to build the resilience of individuals, parents, and families (Department of Health 2016: XVI). There should be a way of effecting a paradigm shift in deeply entrenched social, cultural practices, and concepts such as patriarchy that expose women to risk of HIV (Department of Health 2016: 5). According to the National Strategic Plan (NSP) (2017: 27), unless social and structural factors or drivers of HIV are addressed, public health goals will be undermined. Based on the above, a model to address HIV risky cultural practices is important. Social behaviour change, social mobilisation, and increasing awareness are said to be critical enablers to fight HIV (Department of Health 2016: XX). This cultural approach model guided by Leininger theory of Culture Care Diversity and Universality responds directly to social and structural issues influencing the spread of HIV in the local community as directed by the National Department of Health in South Africa.

#### **6.4.1.3 Local Context –Bushbuckridge sub-District**

Though the context of the model considers the global and national aspects, these two contexts only highlighted the policies and guidelines influencing the management of HIV. The local context is the main determinant of this model. Therefore, several aspects of the local context are taken into consideration as they determine the success or failure of the model. The context of this model is Bushbuckridge Sub-district of Ehlanzeni district which

is found in Ehlanzeni district of Mpumalanga Province., where Bushbuckridge is one of the areas confirmed to have a high burden of HIV in South Africa (Department of Health 2017: 12).

As the model is guided by Leininger theory of Culture Care Diversity and Universality which focuses on the use of languages, cultural practices, beliefs, folklore and rituals of a specific community, this model was developed precisely to be relevant to the context of the Tsonga people of Bushbuckridge who constitute a bigger cultural group among the inhabitants of this area. Though Bushbuckridge has different languages and people from different areas including neighbouring countries such as Mozambique, Zimbabwe, and Swaziland, the focus of the model is for Tsonga People who speak Tsonga language. Most of Tsonga people adhere to the cultural practices and beliefs.

The Tsonga people use their language in the form of proverbs, clan names, taboos and songs, which mostly influence their day-to-day life and behaviours. There are rituals performed by Tsonga people in Bushbuckridge which also form part of the context of this model. The rituals are performed throughout the lives of Tsonga people from before conceptions until after death. The rituals include widow cleansing, family cleansing after death and partner inheritance. Other rituals performed include protection of family members and initiation schools. Though there are free PHC services in Bushbuckridge, the traditional healers are valued as the healers of choice. This is related to their beliefs related to the origin/causes of diseases which are: witchcraft, ancestral call or punishment by ancestors. The community is Patriarchal. Polygamous and intergenerational marriage are valued. Multiple concurrent partnerships are condoned. Though the community is adhering to cultural practices, the community is technological advanced. There is Radio Bushbuckridge which is the leading community radio station and RFM Radio, good internet access. Most of the people have cell phones and the youth are using social media. Health services are supported by traditional leaders, local AIDS council, On Governmental Organisations (NGOs) and several projects addressing health issues. The above context guided the researcher in identifying the necessary input to ensure the achievement of the purpose of the model.

Leininger's work focuses on the discovery of human care diversities and universalities and ways to provide culturally-congruent care to people worldwide. The goals of nursing practice are to improve and to provide culturally congruent care to people that are beneficial, will fit with, and be useful to the client, family, or culture group healthy lifeways [and] to provide culturally congruent nursing care in order to improve or offer a different kind of nursing care service to people of diverse or similar cultures" (Fawcett 2000: 512).

#### **6.4.2 The Input**

Meyer and O' Brien-Pallas (2010: 2831) define input as resources required to carry out a process or provide a service. According to Scheerens (1990: 61), inputs include financial resources, knowledge, and material infrastructure. In order to successfully implement this model, the following inputs are the key to success: Knowledgeable healthcare practitioners, Engaged community structures and Adequate relevant materials. Figure 6.2 presents the structure and the connectedness of the input.

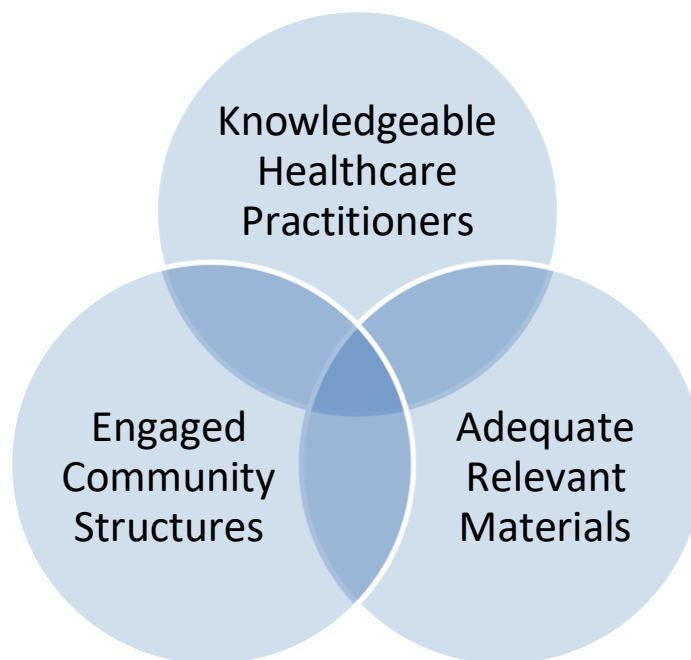


Figure 6.2: The input for Cultural approach model for HIV and AIDS management among Tsonga people.

#### **6.4.2.1 Knowledgeable Healthcare Practitioners**

The model can be successful if there are Health care practitioners who are knowledgeable about Tsonga cultural Practices and how they impact on HIV and AIDS management. The health care practitioners for this module include those who are engaged in Western model of healing and those who are into the traditional way of health care management. The ones involved in western way of health care management include nurses who have undergone formal training, Home Based Care workers, HIV and AIDS counsellors, medical doctors, social worker, psychologists, and Health Promotion Practitioners who work directly with the community. These people render a variety of health care services, including those related to HIV management and care. Though these health care practitioners have experience in their field due to scientific knowledge that they have accumulated for their qualifications and through continued education and experience gained throughout their exposure at work, they should also have insight on the cultural practices of Tsonga people which can impact negatively on their western approach to HIV and AIDS management.

The health care practitioners who are engaged in the traditional way of health management include traditional healers and traditional birth attendants. Traditional birth attendants are women who assist a woman in delivering a baby. As some women in Tsonga culture still deliver at homes assisted by traditional birth attendants who do not have scientific resources to use when helping women to deliver, the traditional birth attendants need to be empowered about the information and also materials to reduce the risk of HIV infection during home deliveries (Evian 2011: 307; van Dyk 2011: 46). Traditional healers are men and women who have undergone training. They may be called n'anga in Tsonga, meaning herbalist or Sangoma meaning diviner (Audet et al. 2017: 3). These can be men or women who know traditional healing. They do not need to have undergone formal education at school. According to van Dyk (2012: 229), Traditional healers can be helpful in HIV prevention. The community knows them; they have authority in their communities. "They are guardians of traditional codes of morality and values" (van Dyk 2012: 229). Traditional healers interpret customary rules of conduct. With their authority, they can introduce new rules which can influence the community on



sexuality issues. They have a role to play and to give advice, about HIV preventive measures van Dyk (2012: 230).

In this study, it was anticipated that traditional healers could be involved. According to a study conducted among traditional healers in Bushbuckridge patients do seek help from traditional healers when they are ill, some traditional healers claim to cure HIV. At times patients are under their care because patients gave false history (Audet et al. 2017: 3). According to Audet et al. (2017: 5) through coordination, traditional healers could be helpful if trained and effectively engaged as they continue to treat HIV patients in rural areas. Their involvement can result in improved HIV patient care. In this model, traditional healers are available in the community to contribute towards HIV preventive strategies. Some refer patients when suspecting HIV infection for HIV testing and treatment (Audet et al. 2017: 4). According to Audet et al (2017: 5), if traditional healers could be trained they can assist in referring for HIV testing, early diagnosis, support adherence. They can refer promptly avoiding herb-drug interactions thus improving outcomes of HIV positive patients and prevent the spread of HIV in the community.

#### **6.4.2.2 Adequate, Relevant Materials**

The researcher realized that books on HIV and AIDS manuals from HIV and AIDS workshops alone are inadequate and only have the general approach to fight HIV, which is Abstain, Be faithful, and Condomise. Communities are unique; thus, it is imperative for AIDS education to be creative and incorporate traditional beliefs and healing methods into AIDS education programmes (van Dyk 2012: 227). For the model to be successful, there should be training manuals written in Tsonga language. The manuals should focus on cultural practices of Tsonga community, the risk entailed and also ways of mitigating those risks. There should also be pamphlets, posters, and brochures written in Tsonga. The information on those pamphlets should be based on local cultural aspects, and the prevention messages should also target the identified HIV risky cultural practices. As there is prolific use of technology, there should also be some video clips in Tsonga language in order to reach youth. There should also be relevant protective materials for the prevention of spread of HIV.

### **6.4.2.3 Engaged Community structures**

In order to achieve the purpose of the model, the other important input is engaged community structures. Community structures in this model include council of traditional practitioners; House of traditional leaders, headmen, traditional healers organisation, community elders, other custodian of traditional knowledge and cultural practices, men's organisations, youth clubs, musicians and traditional dancers, people conducting traditional initiation schools, primary and high school teachers, women's groups or clubs, church leaders and their congregation, commercial sex workers, local government departments and local HIV Council, NGOs and Civic organisations.

All the inputs are interconnected and if there are knowledgeable health care personnel, and engaged community structures, but lacking relevant material, the purpose of the model cannot be realised. The same applies to the presence of engaged community structures and relevant materials without capacitated health care practitioners. The presence of all the identified inputs will determine the relevant processes required to achieve the purpose of the model.

### **6.4.3 The Process**

The World Health Organization (2012: 104) define the process as the manner in which inputs are transformed into outputs or services. A process is defined as the initiatives to accomplish desirable results or output. The processes for this cultural approach model for management of HIV and AIDS in Bushbuckridge will be based on Leininger theory of culture, care diversity and universality. The approach used will be centered around Leininger Cultural Congruent Care Modalities which are (i) Cultural care Preservation or maintenance, (ii) Cultural care Accommodation and Negotiation and (iii) Cultural care Repatterning and Restructuring (1991). The structure of the process for this model is presented in figure 6.3.

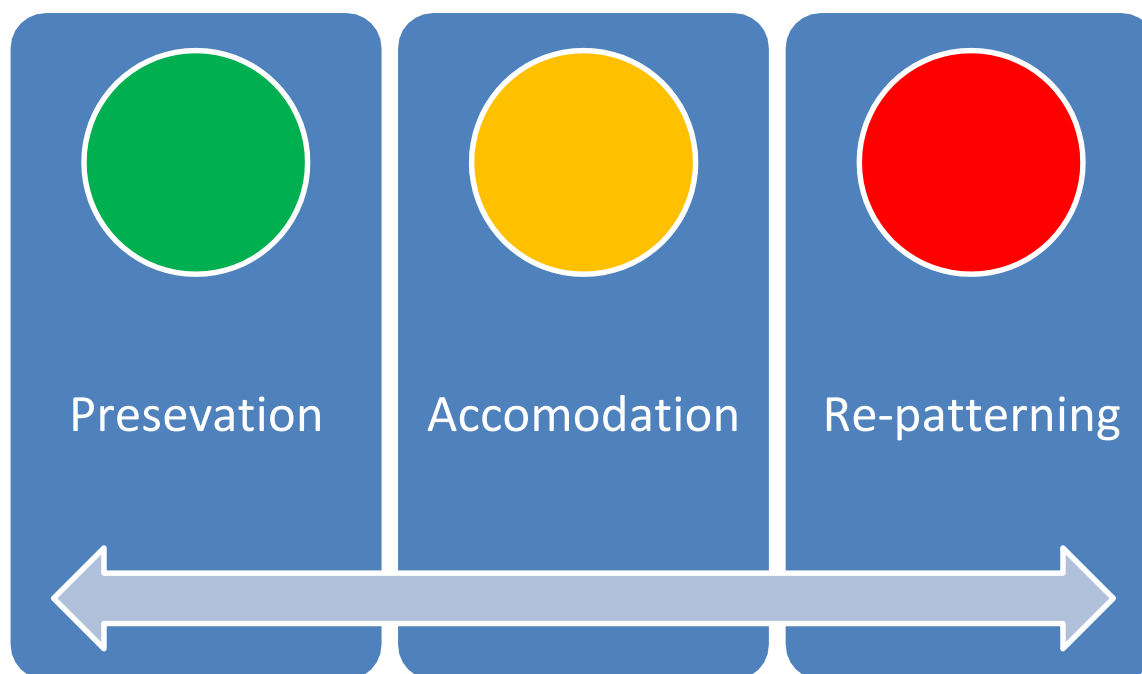


Figure 6.3: The process for Cultural approach model for HIV and AIDS management among Tsonga people.

#### **6.4.3 1 Cultural Preservation or Maintenance**

Cultural care preservation or maintenance focus on assistive, supporting, facilitative, or enabling professional actions and decisions that help people of a particular culture to retain and/or preserve relevant care values so that they can maintain their well-being, recover from illness, or prevent handicaps and or death (Leininger 1991: 30). As the findings indicate that some of the cultural practices in this study can be beneficial in the management of HIV, those practices need to be encouraged and also be supported in order to preserve them. The preservation process should consider all superordinate themes of the study, namely: language, rituals, beliefs regarding the origin/cause of diseases, traditional healers and tattoos.

Though there were several positive aspects which can be deduced from the aspect of language. The fact that Tsonga people enjoy traditional songs and dance, they should be encouraged to continue with that practice. To enhance the practice, there is a need for ensuring that youth also participate in those dances and sing songs with HIV preventive messages. The moment youth are fully engaged in extramural activities such as

traditional dances and songs may reduce their engagement into risky sexual activities. Participating in the extramural activities may also discourage youth from engaging in risky activities such as using drugs and alcohol, which are considered to be predisposing factors to HIV risky sexual activities and non-adherence to antiretroviral treatments. In order to achieve this, all relevant stakeholders such as learners, youth groups, school educators, school health nurses, department of education, traditional leaders and dance group inputs should be harnessed to ensure involvement of people. For this to succeed, there should be an entertainment committee represented by representatives from different sectors with input and also relevant resources such as acquiring relevant dance attires and music instruments.

Other positive aspects highlighted under language which need to be upheld and promoted are issues of proverbs. There are proverbs such as *“wanuna l nhwembe ya nava kambe yi hlangane na vusokoti”* meaning *“A pumpkin plant which spreads may come into contact with ants and be destructed.”* Or *n’wana la nga riliki u ta fela dzobyeni* meaning *it is dangerous for a person who does express his/her emotions ,who does not notify others about his/her difficulties* should be promoted and even taught at different levels. As there are community radios, proverbs like that may even be used as advertisement break messages. There is also a need for the posters which can even be pasted on community Billboards to make people aware that engagement in multiple sexual relationships may predispose people to HIV infection, re-infection and other STIs. Such proverbs should also be used during campaigns, health awareness and community gatherings such as traditional, church, schools and other gatherings.

Other positive aspects related to language are taboos in relation to sexual activities. Messages like telling youth that having sexual activity before menstruating is a taboo, should be encouraged and emphasised as they prohibit young girls from engaging in sexual relationships at an early age. These messages can be discussed at home and even at schools because early engagement into sexual activities increases the risk of HIV infection as there is high possibility of young girls sustaining perenial tears during intercourse. The other positive taboo is the one preventing engagement in sexual activities during menstruation. This also assists in reduction of the risk of HIV infection as

during menstruation, the risk of transmitting or contracting HIV is high due to the raw area in the genital tract and contact with blood. Adherence of this taboo needs to be encouraged and be supported by all the health care practitioners.

There are certain rituals which were practiced and can assist in the prevention of HIV and proper management of people living with HIV. For the success of this model, those rituals need to be promoted and supported in the form of teachings and also using community radios. The rituals identified as positive include: Prohibiting people from drinking beer and engaging in sexual activities for at least three months after the death of a family member (Mathebula 2013:98). This ritual assists in preventing the spread of HIV. The advantage of this break may also be capitalised on by ensuring that, after that break, if people are to engage in sexual intercourse they should have an HIV test before resumption of sexual activities and this may assist in ruling out window period. The other advantage is that, during stressful period such as the death of family member, the viral load for people with HIV may increase, thus increasing the chances of people to spread HIV to uninfected members especially in serodiscordant couples. So, people need to be taught about the advantage of this cool off period after death.

#### **6.4.3.2 Cultural Accommodation or Negotiation**

Cultural care accommodation is also known as negotiation includes those assistive, supportive, facilitative, or enabling creative professional actions and decisions that help people of a designated culture to adapt to or negotiate with others for a beneficial or satisfying health outcome with professional care providers (Leininger 1991: 30). This is mainly done to the practices which may be beneficial if there is some slight alteration in the way they are done. In this instance, the focus is on the practices which may be beneficial in the reduction of the risk for HIV infection or management of HIV provided that the inherent risk factors are reduced or eliminated. The discussion will still be based on language, rituals, beliefs regarding the origin of disease, use of traditional healers and tattoos.

Results indicate that male circumcision is a sacred ritual which is performed to young males. It symbolizes passage to manhood. Male circumcision is one of the procedures recommended by WHO, UNAIDS, and SANAC as one of the strategies for reducing the

spread of HIV. However, how circumcision is conducted by Tsonga people where one instrument is utilized to circumcise the initiates and lack of gloves may contribute to the spread of HIV. In order to reduce this risk, there should be negotiation with the traditional healers and people circumcising (circumcisers) to use one instrument per child and gloves in-between initiates. As this might be costly to the people, parents and the traditional healers should work together to provide whatever materials are used to ensure that there is one instrument used per person. The traditional surgeon, department of health should also provide gloves and disinfectants for circumcising and for care of the wound and to clean hands after each initiate. There should also be involvement of at least one person from the western medicine who will act as a monitor to ensure that the process is followed. To motivate the circumcisers to adhere to the proposed approach, the government should give awards to those who are adhering to the principles of prevention of infection and cross infection.

As the youth (both males and females) spend several weeks during initiation schools, they should be taught about the dangers of unprotected sex and multiple concurrent partners. As youth respect the circumcisors and community elders, there should be dialogues between western health care practitioners and cultural health practitioners including elders on the indigenous way which was used to prevent penetrative sexual intercourse among youth so that those skills would be transferred to the initiates. Some of those ways include issues of touching breast, masturbation, thigh sex which youth might engage themselves in which are considered to be low risk behaviors.

Some of the rituals practiced is partner inheritance. This practice may be good in reducing casual or transactional sexual relationships, which may pose higher risk to HIV infection. The practice also ensures that children are reared in a family where there are both father and mother figure which assist in socialization of children. To limit the risk of HIV infection, community members need to be educated about the importance of testing for HIV first also ruling out the window period before the widow is inherited by the brother or relative of deceased husband or before a widower is allowed to marry a sister or a cousin of the deceased wife. This will limit the risk of the entire family dying of HIV.

The other cultural practice which just needs to be modified is the use of traditional healers by the community in Bushbuckridge. Traditional healers are living in the community and use similar language with the community members. They understand the cultural values of community which make them to be trusted and to be able to provide culturally congruent care. They also use indigenous medicines to treat some of the diseases including opportunistic infections such as herpes zoster, fungal infections, skin conditions, abscess, some childhood diseases and some sort of opportunistic infections. However, the approaches they use especially incision, may contribute to the spread of HIV infection. Sometimes, treating patients without knowledge of their HIV status may also predispose the traditional healers to infection in case they use their hands to apply treatment on the incised bleeding area. In order to reduce risk of HIV transmission and also deteriorating of conditions of people living with HIV, traditional healers will need to be embraced as part of the multidisciplinary team towards the management of the patients. They also need training with regard to opportunistic infections so that they would be able to refer their patients for HIV testing. They also need to be trained on infection control measures and the need for adherence to treatments and drug interaction with herbs. In order to maintain the working relationship, there should be a two-way transfer of the patients from the traditional healer to the hospital and from the hospital back to the traditional healers. This reciprocal way of transfer and patients' management will increase trust and also reduce the number of patients living with HIV and AIDS who cannot be traced.

#### ***6.4.3.3 Re-patterning and Restructuring***

Culture care re-patterning or restructuring includes those assistive, supporting, facilitative, or enabling professional actions and decisions that help a client to change, change, or greatly modify their lifeways for new, different, and beneficial health care pattern while respecting the client's cultural values and beliefs and still encouraging a beneficial or healthier lifeway than before the changes were co-established with the clients (Leininger 1991: 31). In the era of HIV and AIDS, restructuring applies to activities with the high risk of transmitting HIV infections while they have limited significance in promoting individual health.

Examples of such activities include widow cleansing. The activity of widow cleansing is one of the most high-risk activities as the cleanser does not cleanse one person but several widows. In the process, the person also has a family which means that if the person is infected he might end up infecting a lot of people. Also, the act of cleaning a young girl who has not even had sex, it seems to be violating the law of the country as having sex with a person who is under age with or without consent is considered a criminal act. This act may need to be replaced with other ways of cleansing. In order to get an alternative way, the community need to be educated about the risk entailed in those activities through community dialogues where those rituals are being deconstructed and coming up with a replacement. The other activity which needs to be re-patterned is the insertion of treatment for infertility to an “infertile women” through sex with the traditional healer. This activity despite the issue of the risk of HIV infection, it may be contributing to depriving the family from having their own children as there is a greatest possibility that, during the insertion of treatment, the women might end up being impregnated by the traditional healer. The traditional healer may contract HIV and spread it to his wife/wives and future patients.

All the above culture care modalities will be achieved through using different modes of communication media such as community radio station, Facebooks, WhatsApp messages, community dialogues, awareness campaigns, formal trainings, workshops and distribution of pamphlets. To ensure that the information is contextually relevant, the HIV materials used should be written in Tsonga language focusing on the context. The training should be contextually relevant focusing on different target groups based on their ages and roles in a specific culturally appropriate manner. Activities conducted should cover: cultural diversity management, deconstructing certain beliefs and cultural practices, modification of cultural behaviours, conducting research, further research into other practices, deconstructing taboos, challenging language or some language process, modification of rituals, addressing the origin of diseases, empowering traditional healers; empowerment of vulnerable groups especially women and children, reconstructing cultural practices, integrating indigenous knowledge system into management of HIV and AIDS and value clarification is important. The people who should take the leadership role in the entire processes should be Bushbuckridge HIV Council as it has representatives



from all sectors in collaboration with the Bushbuckridge sub-district authorities for the Department of Health.

It is clear based on the findings of the study that training of health care professionals and the community at large on HIV risky cultural practices among the Tsonga people is imperative. Nurse educators and nurses in health services, doctors, social workers, psychologists, HIV and AIDS counsellors, Home Based Care Workers, school health nurses and Health Promotion Practitioners should undergo training to advance preventive strategies. Employees in the public sector should undergo refresher courses and updates on HIV risky Tsonga cultural practices promoting the spread of HIV in the community. If the processes are successively presented it will lead to the desired output.

#### **6.4.4 Output**

Ravitz (2013:354) define output as results, achievements or the products of an activity. In this study, the output results from the involvement of the input in the implementation of processes which are contextually relevant. As the purpose of this cultural approach model is to enhance management of HIV and AIDS among the Tsonga people in Bushbuckridge, the following are expected output: Increased knowledge about safe cultural practices through modification of HIV risky cultural practices, improved health-seeking behaviour, reduction of new HIV infections and reduction of HIV and AIDS related deaths. The output are cyclical and dependant on each other. This is presented in figure 6.4.



Figure 6.4 Output of a cultural approach model for HIV and AIDS management among the Tsonga people.

#### 6. 4.5 The Complete structure a Cultural Approach Model for HIV and AIDS Management Among the Tsonga People.

Figure 6.5 present a complete structure of the model. The three rectangles represent the context in which the model is applicable. The outermost rectangle is global context followed by national context. The innermost rectangle is the local context, namely Bushbuckridge. The innermost context determines the input necessary for implementation of this model. The input is represented by a basic Venn figure which show overlapping or interconnected relationships. In this case the relationship of knowledgeable healthcare practitioners, Engaged community structures and Adequate relevant materials. The availability of the above input is responsible for ensuring that the processes take place. The processes for this model are cultural congruent modalities namely: Cultural care Preservation or maintenance, (ii) Cultural care Accommodation and Negotiation and (iii) Cultural care Re-patterning and Restructuring. These are presented in the form of continuous picture link which show interconnection of the information. The circular shapes are coloured to show the role of the activity in relation to HIV management. The green colour indicate that the activity has positive role to reduce risk of HIV infection, the amber colour means that the practice itself is good in the prevention of HIV but the way it is done, it may pose risk of HIV infection whereas the red colour

indicate that the activity is dangerous as it poses high risk of infection whilst have limited positive health. Those colours also determined the steps to be taken. Successful implementation of the process will lead to the desired output of the model which are: modification of HIV risky Tsonga cultural practices, improved health-seeking behaviour, reduction of new HIV infections and reduction of HIV and AIDS-related deaths.

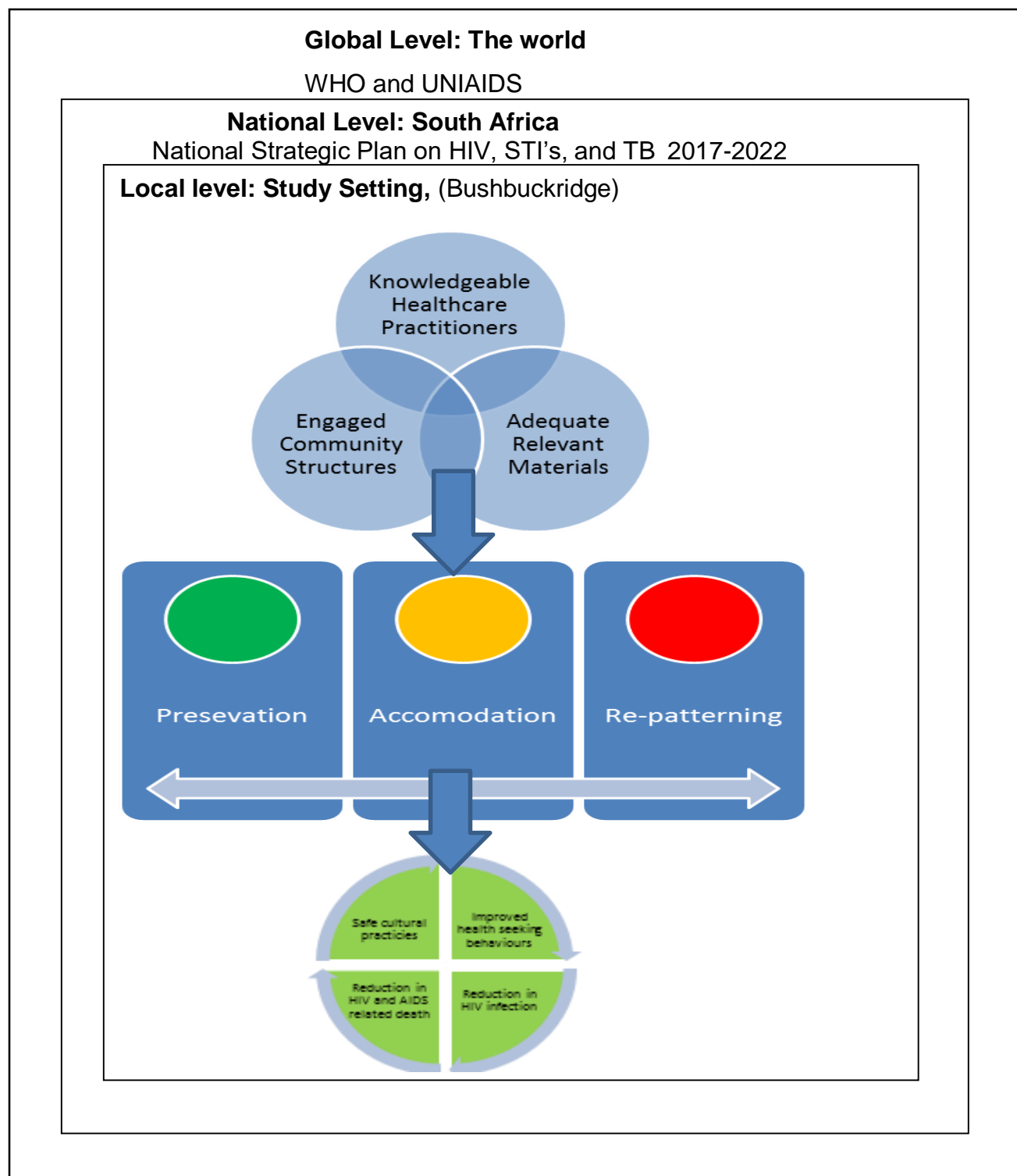


Figure 6.5: The structure of a cultural approach model for HIV and AIDS management among the Tsonga people.

## **6.5 ASSUMPTION OF THE CULTURAL APPROACH MODEL FOR HIV AND AIDS MANAGEMENT AMONG THE TSONGA PEOPLE.**

The assumptions of this model are as follows:

- Proper understanding of context will lead to proper identification of the input.
- If the health care providers are knowledgeable health care practitioners, with engaged community structures and adequate relevant materials, there would be proper implementation of culturally congruent modalities
- Proper understanding of cultural practices and HIV risk entailed will lead to proper implementation of Cultural care modalities.
- Preservation or maintenance of cultural activities which assist in reduction of HIV infection will improve interaction between all health practitioners and the community.
- Successful Cultural Care Accommodation or Negotiation will assist in the reduction of risky cultural practices and thus lead to the reduction of new HIV infections,
- Cultural care Re-patterning or Restructuring may assist the community to abandon practices which are harmful and non-beneficial to community.
- Successful implementation of cultural care modalities in relation to HIV and AIDS will lead to modification of HIV risky cultural practices, improved health-seeking behaviour, reduction of new HIV infections and reduction of HIV and AIDS related deaths.
- The proper implementation of this model will lead to improved management of HIV and AIDS.

## **6.6 TRUSTWORTHINESS OF THE CULTURAL APPROACH MODEL FOR HIV AND AIDS MANAGEMENT AMONG THE TSONGA PEOPLE IN BUSHBUCKRIDGE.**

To ensure trustworthiness of the cultural approach model for HIV and AIDS management among the Tsonga people in Bushbuckridge, the researcher was supervised throughout the process of model development by a supervisor who is an expert in HIV/AIDS management and also developed a management model for HIV in rural-based university. The supervisor has also supervised several students who have developed management model for Prevention of Mother to Child Transmission of HIV and support model for HIV

serodiscordant couples. The supervisor guided the researcher in refining the model and all the elements of the model to ensure alignment with literature, research findings and the theoretical background. After having a near-final draft of the model, the researcher engaged the following experts: (i) the academics who are expert in Tsonga language and Tsonga culture and beliefs, (ii) researchers who are experts in qualitative research and model development, and (iii) health care practitioners (both traditional and those involved in western medicine) who are involved in the management of HIV and AIDS and (iv) the chairperson of traditional healers in Bushbuckridge to provide input. After their input, the researcher integrated their input to refine the model. When the researcher and the supervisor were satisfied with the refined draft, the researcher has consulted independent experts for model development from three different universities to evaluate the model using the Delphi technique. Hasson and Keeney (2011: 1696) define Delphi technique as a process employed to collect the opinion of experts on a particular subject. The criteria for selecting participants for Delphi technique were as follows: Having Ph.D.; supervised doctoral students who have developed models, framework or strategy; knowledgeable about HIV and AIDS, Cultural practices and Leininger theory of culture, care and diversity. To conduct Delphi, the researcher contacted the informants/experts to discuss the model, then send the evaluation tool to the expert. The tool was based on Chinn and Kramer (1999) criteria which are simplicity, clarity, scope, accessibility and importance. When feedback was provided, where the researcher did not understand, clarification from the experts was requested.

The model was also presented to the Bushbuckridge AIDS Council as the council is composed of all relevant stakeholders who form part of the input of the model to also evaluate and discuss the model based on the criteria. Feedback which necessitated changes in the model were incorporated to ensure that the model meet all criteria. After several refinements, the final version of the model received the following comments from the members of AIDS council and experts.

- **Clarity**

The expert mentioned that the model is easy to understand and relevant to the context. The way the model is written using the language and terms that are familiar to all the relevant stakeholders who will be affected by the implementation of the model.

- **Simplicity**

The AIDS council members and experts mentioned that the model is simple and user-friendly.

- **Generalisability**

All the experts mentioned that the model can be utilized not only for Tsonga people in Bushbuckridge but can also be utilized for other ethnic groups in South Africa and even the continent who have similar practices and beliefs which may have negative impact on HIV and AIDS management. They further mentioned that the model can also be used to address other cultural practices which affect health in general.

- **Accessibility**

The experts asserted that the model is relevant, significant, and clear and will have a positive impact on HIV and AIDS management. They suggested that the model should be in hard copy and also soft copies for those who are using social media. The model should also be on the website of the Department of Health and also online so that people could be able to access it. They suggested that the information should also be translated to Tsonga language and be shared on the Bushbuckridge community radio.

- **The importance of the model**

The model was well received by the AIDS Council members who feel that it is user-friendly and may assist in the reduction of HIV and AIDS in Bushbuckridge.

## **6.7 APPLICATION FOR THE CULTURAL APPROACH MODEL FOR HIV AND AIDS MANAGEMENT AMONG THE TSONGA PEOPLE IN BUSHBUCKRIDGE.**

After presenting the model to different stakeholders for the assessment of relevance, there was consensus that the model can be utilised in different settings. The following are some of the areas where the model can be utilised:

- Entire Bushbuckridge community regardless of ethnic groups

- Other ethnic groups in South Africa where they have similar beliefs and practices
- Other African countries who have similar practices and beliefs which may have impact on HIV and AIDS management.
- Nursing colleges and Nursing schools to teach nurses on cultural congruent care.
- Department of Education to enhance HIV and AIDS prevention, care and support strategies.

## **6.8 CONCLUSION**

The cultural approach model for HIV and AIDS management among the Tsonga people in Bushbuckridge was developed guided by Leininger theory of culture care diversity and universality. The CIPO model (Scheerens 1990) was used to organise the structure of the model. The purpose of the model was highlighted followed by the elements of the model which covers the global, national and local context; the input which include the healthcare practitioners, relevant resources and engaged community structures. The process of the model which include different cultural care congruent modalities which are Cultural Care Preservation or maintenance, Cultural care Accommodation and Negotiation and, Cultural care Re-patterning and Restructuring was also presented. This was followed by the output of the model which are: modification of HIV risky cultural practices, improved health-seeking behaviour, reduction of new HIV infections and reduction of HIV and AIDS related deaths. The researcher also presents the assumptions of the model, measures to ensure the trustworthiness of the model and the applicability of the model. The next chapter provides summary, conclusion and recommendations of the study.



## **CHAPTER 7: SUMMARY, CONCLUSION, AND RECOMMENDATIONS OF THE STUDY**

### **7.1 INTRODUCTION**

This ethnographic study was aimed at gaining an in-depth understanding of cultural practices and beliefs that may affect management of HIV and AIDS among Tsonga people in Bushbuckridge to develop a contextual cultural approach model for HIV and AIDS management. The objectives of the study were to:

- Explore and describe cultural practices and beliefs that may have an impact on the management of HIV and AIDS among Tsonga people in Bushbuckridge..
- To develop a contextual, cultural approach model for HIV and AIDS management for Tsonga people in Bushbuckridge.

The previous chapter presented the cultural approach model for HIV and AIDS management among the Tsonga people in Bushbuckridge. This chapter outlines the major findings of the study based on the objectives. The chapter also presents the recommendations and limitations of the study.

### **7.2 SUMMARY OF RESULTS**

The summary of the results is presented based on the research which was designed to address the two research questions.

#### **7.2.1 What are the Tsonga Cultural Practices and Beliefs that May Have a negative Impact on the Management of HIV and AIDS Among Tsonga People in Bushbuckridge?**

Findings indicated that language, rituals, beliefs related to the origin of diseases, traditional healers, and tattoos are among Tsonga cultural practices and beliefs that have an impact on the management of HIV and AIDS. Some of the practices increase the risk of HIV infection while some assist in the reduction of the risk of HIV infection.

### **7.2.2 What can be Done to Enhance the Management of HIV and AIDS Among Tsonga People in Bushbuckridge?**

To enhance management of HIV and AIDS among the Tsonga people in Bushbuckridge, the researcher developed a cultural approach model for HIV and AIDS management among the Tsonga people in Bushbuckridge guided by Leininger theory of culture care diversity and universality. To organise the model, the researcher used CIPO model to guide the elements of the cultural approach model. Though the model takes into consideration the global and national context, the main focus was the local context in particular Bushbuckridge. The success of this model is dependent on the availability of knowledgeable healthcare practitioners, relevant resources and engaged community structure. The process of the model includes Cultural Care Preservation, Cultural care Accommodation, and Cultural care Re-patterning. The expected outputs of the model are modification of HIV risky cultural practices, improved health-seeking behaviour, reduction of new HIV infections and reduction of HIV and AIDS-related deaths.

## **7.3 RECOMMENDATIONS**

The recommendations of this study focus on implementation of the model; Nursing Education and Practice; and further research.

### **7.3.1 Recommendations for the Implementation of the Cultural Approach Model for HIV and AIDS Management Among the Tsonga People in Bushbuckridge**

The following are recommendations related to implementation of the model:

- The model should be implemented using multidisciplinary approach.
- For the model to be successful, there should be engagement of all relevant stakeholders.
- The government should be fully committed to ensure the success of the model.
- When implemented to a slightly different context, the model should be adapted to meet the context.
- The traditional leaders should be fully involved to ensure the success of the implementation of the model.
- Traditional healers should play their role in collaboration with Department of health

- There should always be mutual respect among all the stakeholders involved in the implementation of the model.
- The leaders in model implementation should be knowledgeable of cultural practices and beliefs of the Tsonga people or the people which the model is adapted for.
- To ensure sustainability and buy in, the community should be trained about the model using the language which they understand better.
- Marketing of the model should be done using relevant means of communication, including social media.
- The model can be utilised at schools to assist learners in reducing the risk of being infected with HIV.
- The model can be implemented to address other cultural practices which have negative impact on the management of other health issues, including non-communicable diseases.

### **7.3.2 Recommendation for Nursing Practice and Education**

The following are the recommendations for nursing practice and nursing education:

- The utilization of cultural approach model should be taught early in the Nursing profession to ensure that nurses provide culturally congruent care.
- The Nursing curriculum needs to be transformed in order to embrace the cultural practices and prepare nurses to mitigate harmful cultural practices or promote positive cultural practices.
- If possible, Nursing Education books and HIV and AIDS manuals should consider indigenous knowledge system.

### **7.3.3 Recommendations Regarding Further Research**

The following are recommendations regarding further research:

- There should be a study conducted to evaluate the effectiveness of the model.
- A quantitative study needs to be conducted with different stakeholders in order to check their perceptions regarding the model.

- A similar study should be conducted in a different area in order to compare cultural practices.

#### **7.4 ORIGINAL CONTRIBUTION**

This study contributed valuable information to the body of knowledge. Except for discovering numerous risky Tsonga cultural practices contributing towards the spread of HIV in Bushbuckridge, a cultural approach model for HIV and AIDS management among the Tsonga people in Bushbuckridge was developed. Implementation of the model can assist in modification of HIV risky cultural practices, improved health-seeking behaviour, reduction of new HIV infections, and reduction of HIV and AIDS-related death. The model can be utilised to the entire Bushbuckridge regardless of ethnic groups, other ethnic groups in South Africa where they have similar beliefs and practice, other African countries who have similar practices and beliefs which may have negative impact on HIV and AIDS management. The model can also be utilised at Nursing Colleges and Nursing Schools to teach nurses on the provision of cultural congruent approach when managing HIV and AIDS. The Department of Education and Department of Health may utilise the model to enhance HIV and AIDS prevention, care and support strategies.

#### **7.5 LIMITATIONS OF THE STUDY**

The study focused only on Tsonga people who met inclusion criteria. This is a limitation as Bushbuckridge is composed not only of Tsonga people but people from other areas and countries who are also interacting with Tsonga people in Bushbuckridge. The researcher used mainly interviews to collect data which is a limitation as ethnographic studies also depend fully on the observation. However, observation of different cultural activities was not allowed as the informants mentioned that it is a taboo to allow a person who has not undergone some rituals to observe the performance of those rituals. Most of the cultural practices such as rituals where traditional healer visits at night for family protection is done privately including taking of a widow to the river and especially in relation to initiation schools, they are seasonal and they were not performed during the period when data was collected. Only one traditional healer secured an appointment and took part in the study request was made in the meeting of traditional health practitioners..

## **7.6 CONCLUDING REMARKS**

This ethnographic study explored and described cultural practices and beliefs that may have a negative impact on the management of HIV and AIDS among Tsonga people in Bushbuckridge. The findings of the study indicated that there are several risky cultural practices and beliefs among the Tsonga people in Bushbuckridge, which affect the management of HIV and AIDS. Based on the findings of the study and literature the researcher developed a contextual, cultural approach model for HIV and AIDS management for Tsonga people in Bushbuckridge. The model development was guided by Leininger theory of culture, care, diversity, and universality. Based on the outcome of the study, the researcher makes several recommendations in relation to implementation of the model, Nursing Practice and Education, and further research. The study has contributed to the body of knowledge in relation to cultural practices and management of HIV and AIDS. Except for discovering numerous risky Tsonga cultural practices contributing towards the spread of HIV in Bushbuckridge, a cultural approach model for HIV and AIDS management among the Tsonga people in Bushbuckridge, Implementation of the model can assist in modification of HIV risky cultural practices, improved health-seeking behaviour, reduction of new HIV infections and reduction of HIV and AIDS-related deaths. The model can be utilised to enhance nursing education and practice and further research.

## REFERENCES

- Abdool Karim, SS & Abdool Karim, Q. 2010. *HIV/AIDS in South Africa*. 2<sup>nd</sup> edition. Cape: Cambridge University Press.
- Afolayan, F. 2004. *Culture and customs of South Africa*. Westport: Greenwood Press.
- Airhihenbuwa, CO & Obregon, R. 2000. A Critical Assessment of Theories / Models used in Health Communication for HIV/AIDS. *Journal of Health Communications: International Perspectives*, 5 (1): 5-15.
- Aniebue, PN & Aniebue, UU. 2009. HIV/AIDS-related knowledge, sexual practices and predictors of condom use among long-distance truck drivers in Nigeria. *South African Journal of HIV Medicine*, 34: 54-56.
- Audet, CM, Ngobeni S & Wagner RG. 2017. Traditional healer treatment of HIV persists in the era of ART: a mixed methods study from rural South Africa. *Complementary and Alternative Medicine* 17(4): 1-6.
- Ayapo, JM. 2009. *Exploring Nigerian Adolescent Student's Perceptions of HIV/AIDS and Their Attitudes to Prevention Methods: A Psycho of Educational Perspective*. Pretoria: Unisa.
- Baloyi, LF. 2009. *Problems in providing Primary Health Care services, Limpopo Province*. Unisa: Pretoria.
- Banda, F & Kunkeyani. 2015. Renegotiating cultural practices as a result of HIV in the eastern region of Malawi. *Cultural Health and Security*, 17(1): 34-47.
- Bezuidenhout, F. 2013. *A reader on selected social issues*. Ninth impression. Pretoria: Van Schaik Publishers.
- Booth, A, Papaioannou, D. & Sutton, A. 2012. *Systematic Approaches to a Successful Literature Review*. London: Sage Publications.

Botma, Y, Greeff, M, Mulaudzi, FM & Wright, SCD. 2015. *Research in Health Sciences*. Pinelands: Pearson Education.

Brink, H, Van der Walt C & Van Rensburg, G. 2018. *Fundamentals of Research Methodology for Health Care Professionals*. 3<sup>rd</sup> edition. Cape Town: Juta. & Ltd.

Brink, H. 2009. *Fundamentals of Research Methodology for Health Care Professionals*. Cape Town: Juta.

Bruce, JC & Klopper, HC. 2010, 'A model for incorporating specialist nurse education into a university context. Part 1: Methodological perspectives'. *Health SA Gesondheid*, 15(1): 494-500. DOI: 10.4102/hsag.v15i1.494.

Bryman, A, Bell, E, Hirschsohn, P, Dos Santos, A, du Toit, J, Masenge, A, van Aardt, I & Wagner, C. 2014. *Research Methodology: Business and Management Context*. Cape Town: Oxford University Press.

Burns, N & Grove, SK. 2005. *The Practice of Nursing Research Conduct, Critique and Utilization*. St Louis: Elsevier/Saunders.

Campbell, C. 2010. Political will, traditional leaders and the fight against HIV/AIDS: A South African case study. *Psychological and Socio-medical Aspects of AIDS/HIV*, 22 (52): 1637-1643.

Carter, M. 2018. HIV-related factors not associated with increased risk of suicide among people with HIV in France. AIDS Map, online, available at <https://www.aidsmap.com/news/jun-2018/hiv-related-factors-not-associated-increased-risk-suicide-among-people-hiv-france>. (Accessed 3 June 2019).

Chinn, PL & Kramer, MK. 1999. *Theory and Nursing: Integrated Knowledge development*. 5<sup>th</sup> Edition. London: CV Mosby.

Concise Oxford English Dictionary. 2011. 12<sup>th</sup> edition. New York: Oxford University Press.

Coovadia, HM & Wittenberg, DF. 2010. *Paediatrics & Child Health: A Manual for Health Professionals in the Third World*. Cape Town: Oxford University Press.

Crang, M & Cook, I. 2007. *Doing Ethnographies*. London. SAGE Publication Ltd.

Creswell, JW & Poth, CN, 2018. *Qualitative inquiry and research design: choosing among five approaches*. 4<sup>th</sup> edition. Los Angeles: SAGE.

Dadoo, Y, Ghyoot, V, Lephoko, D & Lubbe, G. 1997. *Multicultural Sensitivity for Managers*. Pretoria: Unisa Centre for Business Management.

David, M. 2015. *WordPress Search Engine Optimization*. Birmingham: Packet Publishing Ltd.

De Palma, R & Francis, D. 2014. Silence, nostalgia, violence, poverty what does "culture" mean for South African Sexuality. *Culture Health and Sexuality*, 16(5): 547-561.

De Vos, AS. 2011. *Research at grassroots: for social sciences and human services profession*. 4<sup>th</sup> Edition. Pretoria: Van Schaik.

Department of Health, 2016. *Guidelines for Expanding Combination Prevention and Treatment Options for Sex Workers: Oral Pre-Exposure Prophylaxis (PrEP) and Test and Treat (T&T)*. Pretoria: Department of Health South African Government.

Dibakoane, T. 2013. "I can cure AIDS": Bushbuckridge news. 192.

Dibua, UE. 2010. Socio-economic and socio-cultural predisposing risk factors to HIV/AIDS: case study of some locations in Eastern Nigeria. *The Internet Journal of Tropical Medicine*, 6 (2):1-12.

Dikixinary ya Xitsonga/ English Dictionary. Xitsonga. 2006. National Lexicography. Johannesburg: Phumelela Publishers (Pty) Ltd.



Evian, C. 2011. *Primary HIV Clinical Care for adults, children, and pregnant women: A practical guide for health care personnel in primary care centres*. Melville: Jacana Media.

Fawcett, J. 2000. *Analysis and Evaluation of Contemporary Nursing Knowledge: Nursing Models and Theories*. Philadelphia, PA: F. A. Davis.

Fehringer, J, Babalola, S, Kennedy, C, Kajula, L, Mbwambo, J & Kerrigon, D. 2013. Community perspective on parental influence on engagement in multiple concurrent sexual partnerships among youth in Tanzania. *Implications for HIV Presentation Programming AIDS Care*, 25(2): 207-214.

Fink, A. 2005. *Conducting Research Literature Reviews*. Thousand Oaks: Sage Publications Inc.

Flick, U. 2014. *An introduction to Qualitative Research*. 5<sup>th</sup> edition. London: SAGE.

Fuller, L. 2008. *African Women's Unique Vulnerabilities to HIV/AIDS: Communication Perspectives and Promises*. New York: Palgrave Macmillan.

Grove, SK, Burns, N & Gray, JR. 2013. *The practice of nursing research: Appraisal, Synthesis, and Generation of Evidence*. Missouri: Elsevier.

Grove, SK, Gray JR & Burns N, 2015. *Understanding Nursing Research: Building an Evidence-Based Practice*. 6<sup>th</sup> edition. Missouri: Elsevier.

Halala, P .2012. A critical historical study of the form and content of the response of the Vatsonga to Swiss Christian Missionary activities: the case of Valdezia, Elim, Kurulen and the surrounding areas, 1873-1994: South Africa: Limpopo. Online. Available at: <http://worldcat.org/identities/lccn-no2017145654/>. (Accessed 11 May 2018)

Hallal, RC, Raxach, JC, Barcellos, NT & Maksud, I. 2015. Strategies to prevent HIV transmission to serodiscordant couples. *Revista Brasileira de Epidemiology*, 18: 169-182.

Harper, GW, Tyler, AT, Bruce D, Graham L & Wade RM 2016. Drugs, sex, and condoms: Identification and interpretation of Race-Specific cultural Messages Influencing Black Gay and Bisexual Young Men Living with HIV. *American Journal of Community Psychology*. 58 (3-4): 463-476.

Hasson, F & Keeney, S. 2011. Enhancing rigor in the Delphi technique research.

*Technological Forecasting & Social Change*, 78: 1695-1704.

Head, T. 2017. Just how many wives does Jacob Zuma have, and who are they? The South African. On line, available at <https://www.thesouthafrican.com/south-africans-abroad/how-many-wives-does-jacob-zuma-have>. (Accessed 23 July 2019).

Hornby, AS. 2017. *Oxford Advanced Learner's Dictionary: International Student's Edition*. 8<sup>th</sup> Edition. Oxford University Press: Oxford

Integrated Development Plan (IDP). 2016. Bushbuckridge Local Municipality. IDP. 2011-2016.

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2015. How AIDS changed everything. MGD 6: 15 years, 15 lessons of hope from the AIDS response. Fact Sheet: 2014 Global Statistics. Available website: [www.unaids.org](http://www.unaids.org). (Accessed on July 18, 2019).

Junod, HP. 2010. Vutlhari bya Vatsonga (Machangana): The Wisdom of the Tsonga – Shangaan People. Braamfontein: Sasavona Publishers.

Kenyon, C, Osbak, K, & Boyze, J. 2015. Variation of sexual scripts. *Relating to Concurrency by Race, Class, and Gender in South Africa*, 52(8):878-886.

Lambane, C & Mthombeni, M. 2014. Rivomba ra Vutsonga: Buku ya mfuwo wa rixaka Giredi ya 12. Cape Town: Mangalani Publishing.

Leclerc-Madlala, S, Simbayi, L, & Cloete, A. 2009. The sociocultural aspect of HIV/AIDS in South Africa 25 years on. *Spring Science + Business Media*, 13-25.

Leedy, PD & Ormrod, JE. 2013. *Practical Research Planning and Design*. 9<sup>th</sup> edition. New Jersey: Pearson Education.

Leininger, MM. 1991. Culture care diversity and universality: A theory of nursing. In George, J. (Ed.). *Nursing Theories: The Base for Professional Nursing Practice*. Norwalk, Connecticut: Appleton & Lange.

Lincoln, YS & Guba, EG. 1985. *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Madiba, S & Ngwenya, N. 2017. Cultural practices, gender inequality, and inconsistent condom use increase vulnerability to HIV: Narratives from married and cohabiting women in rural communities in Mpumalanga Province: South Africa. *Global Health Action*, 10 (13): 23-45.

Malungana, SJ. 2006. Mfuwo wa rixaka I xifuva. Polokwane: NAM Publishers.

Marhanele, MM & Bila, V. 2016. Tihlungu ta rixaka. Dikixinari ya ririmi ra Xitsonga. Polokwane: Timbila Poetry Project.

Mathebula, M. 2013. *800 Years of Tsonga History (Year 1200-Year 2000)*. Burgersfort: Sasavona Publishers and Booksellers.

Mavhandu-Mudzusi, AH. 2014. Management of Staff and Students Living with HIV and AIDS in South African Rural-Based University. *Journal of Human Ecology*, 47(3) 209-217.

McClellan, M. 2012. *Primary Health Care Fresh Perspective*. Cape Town. Pearson Education.

Meyer, RM & O'Brien-Pallas, LL. 2010. Nursing Service Delivery Theory: an open system approach. *Journal of Advanced Nursing*, 66(12): 2828-2838. [Online]. Available Blackwell

Publishers website: doi.10.1111/j.1365-2648.2010.05449.x. (Accessed 14 September 2018).

MNUALL/301/2015. University of South Africa. Department of Health Studies. General tutorial letter for proposal, dissertation and thesis writing. Pretoria.

Mogotlane, S, Chauke, M, Matlakala, M, Mokoena, J & Young, A. 2014. *Juta's Complete Textbook of Medical-Surgical Nursing*. Cape Town: Juta and Company Ltd.

Mogotlane, SM, Hazeli, E & Mthembu B.2007.Women's cultural perspectives on reasons for HIV/AIDS prevalence in a rural area of KwaZulu-Natal Province. *South African Journal of Nursing and Midwifery*, 9 (2): 35-43.

Mouton, J. 2001. *How to Succeed in Your Master's and Doctoral Studies: A South African Guide and Resource Book*. Pretoria: Van Schaick.

Mulaudzi, FM. 2005. Attitudes, beliefs, and practices of VhaVenda in sexually transmitted infections. *Indilinga African Journal of Indigenous Knowledge Systems*, 4 (1): 323-339.

Muller, J & Moyo, N. 2011. The influence of cultural practices on the HIV and AIDS pandemic in Zambia. *HTS Theologies Studies/ Theological Studies*, 67 (3): 770-775.

Ngcobo, S. 2014. World AIDS DAY Commemoration 2013. Get wise, Get tested, Get Circumcised. *Nursing Update. The Magazine for the Caring Profession*, 38 (12): 20.

Nkuna, T & Mboweni, P. 2015. *Ndzalama. Mfuwo wa Rixaka ra Vatsonga:Ririmi ra le kaya*. Florida Hills: Vivilia.

Nxumalo, J.2014. The long battle against HIV/AIDS in Swaziland. *Nursing Update. The Magazine for the Caring Profession*, 39(2): 32-33.

Nyati-Jokomo, Z, January, J, Ruparanganda, W, & Chitsike, I. 2016. Risky traditional practices and prevention of mother to child transmission of HIV: the case of chlota community in Zimbabwe. *AIDS Care*, 28(1): 52-56.

Nyoni, C. 2008. *Socio-cultural Factors and Practices that Impede upon Behavioral Change of Zimbabwean Women in the Era of HIV/AIDS*. Unisa: Pretoria.

O' Brein, S & Broom, A. 2013. Gender, Cultures and Changing Attitudes. *Culture Health and Sexuality*, 15 (5):583-597.

Ombere, S, Nyambedha, E & Bukachi, S. 2015. Wimbo: Implications for risk of HIV infection among circumcised fisherman in Western Kenya. *Culture Health and Sexuality*, 17(9): 1147-1154.

Perry, B, Oluoch, L, Agot, K, Taylor, J, Onyango, J, Ouma, L, et al. 2014. Widow cleansing and inheritance among the Luo in Kenya: the need for additional women-centered HIV prevention options. *Journal of the International AIDS Society*, 17(1): 19010.

Peters, E, Kambewa, D & Walker A.2010: Contestations over "Tradition" and "Culture" in a time of AIDS. *Medical Anthropology*, 29 (3): 278-302.

Polit, D. F., & Beck, C. T. 2017. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. 10<sup>th</sup> edition. Philadelphia, PA: Wolters Kluwer.

Polit, FP & Beck, CT. 2008. *Nursing Research Generating and Assessing Evidence for Nursing Practice*, 9<sup>th</sup> edition. Philadelphia: Wolters Kluwer Health/ Lippincott, Williams & Wilkins.

Porritt, K, Gomersall, JS & Lockwood, C. 2014. JBI's Systematic Reviews: Study Selection and Critical Appraisal. *The American Journal of Nursing*, 114(6): 47-52.

Ramjee, G & Daniels, B. 2013. Women and HIV in Sub-Saharan Africa. *AIDS research and Theory, AIDS Research and Therapy*,10:30 1-9.

Rosenberg, MS, Gomez-Olive, FX, Rohr, JK, Houle, BC, Chodziwadziwa, WK, Wagner, RG, Salomon, JA, Kahn, K, Berkman, LF, Tollman, SM & Barnighaysen, T. 2017. Sexual behaviors and HIV Status: A Population-Based Study Among Older Adults in Rural South Africa. *Acquired Immune Deficiency Syndrome*, 14 (1): 9-17.

Saddiq, A, Tolhurst, R, Lallo, D & Theobald, S. 2010. Promoting vulnerability or resilience to HIV? A qualitative study on polygamy in Maiduguri, Nigeria. *AIDS Care: Psychological and Socio-Medical Aspects of HIV/AIDS*, 22 (2) :146-151.

Sandy, P & Mavhandu-Mudzusi, A. 2014. Staff and student perception of an HIV/AIDS Strategy: A case study of a South African Rural based university. *Mediterranean Journal of Social Sciences MCSER Publishing*, 5(20): 2729-2733.

Scheerens, J. 1990. School Effectiveness and the Development of process Indications of school funding. School functioning. *School Effectiveness and School Improvement*, 1: 61-80. doi.10.1080/0924345900010106. CIPPO.

Setswe, KG, Naude, M & Zungu L, 2011. *Basic Community Health Nursing*. 2<sup>nd</sup> edition. Cape Town: Pearson Education.

Smit, PJ, Cronjé, GJ, Brevis, T & Vrba, MJ. 2007. *Management Principles – A Contemporary Edition for Africa*. 4<sup>th</sup> edition. Cape Town: Juta

Sovran, S. 2013. Understanding culture in sub Saharan Africa. *Journal of Social Aspects of HIV/AIDS*, 10(1): 32-51.

Stephnson, R, Winter, A & Efstron, M. 2013. Community environment shaping transactional sex among risky transactional sexually active men in Malawi, Nigeria and Tanzania. (n.d.). *AIDS Care*, 25(6): 784-792.

Thwala, M, Jones, LK & Holroyddd, E. 2012. *An Ethnographic Account of the Beliefs, Values, and Experiences of Rural Swazi Women During Childbirth: Evidence-Based Midwifery*. The Royal College of Midwives.

Tjale, A & de Villiers, L (eds). 2004: *Cultural Issues in Health and Health Care*. Cape Town: Juta.

UNAIDS. 2011. UNAIDS Terminology Guidelines. Geneva: UNAIDS.

UNAIDS. 2016. Fact sheet –Global HIV Statistics.

Van Dyk, A., 2012. *HIV AND AIDS Education, Care and Counselling: A multidisciplinary approach* .5<sup>th</sup> edition. Cape Town: Pearson Education.

VasutheVan, S & Mthembu, S. 2014. *De Haan's Health of Southern Africa*. 10<sup>th</sup> edition. Cape Town: Juta & Company.

Vethe, CB. 2011. *The Role of Life Orientation in Addressing HIV/AIDS IN KwaZulu –Natal Secondary Schools*. Pretoria: Unisa.

Walker, LO & Avant, KC. 1995. *Strategies for Theory Construction in Nursing*. Cape Town: Appleton & Lange Norwalk.

Walker, LO & Avant, KC. 2011. *Strategies for Theory Construction in Nursing*. 5<sup>th</sup> Edition. Norfolk: Appleton-Century-Crofts

Walyn, D & Maitshotlo, B. 2010. The role of South African traditional health practitioners in the treatment of HIV/AIDS: A study of their practices and use of herbal medicine. *South African Journal of HIV Medicine*, 38.11-16.

Wayne, G. 2014. Madeline Leininger's Transcultural Nursing Theory. Available at: Nurses Labs: <https://nurseslabs.com/madeleine-leininger-transcultural-nursingtheory/>. (Accessed 14 September 2018).

Welman, C, Kruger, F & Mitchell, B. 2010. *Research Methodology*. Cape Town: University Press.

Wizmap 2016. Bushbuckridge. (Online) available at <https://wazimap.co.za/profiles/municipality-MP325-bushbuckridge>. (Accessed 15 May 2018).

World Health Organisation. 2012. Guidance on couple HIV testing and counselling, including anti-retroviral for treatment and prevention in sero-discordant couples: Recommendations for a public health approach. Geneva: WHO.

World Health Organisation. 2015. Health MGDs and post 2015 Sustainable Development Goals (SGDs). Geneva: WHO. Available website: <http://www.afro.who.int/en/media-centre/afro-feature/item/8030-health-mdgs-and-post-2015-sustainable-development-goals-sdgs.html>. (Accessed 2 January 2019).



## ANNEXURE A: UNISA Ethical Clearance Certificate



**UNIVERSITY OF SOUTH AFRICA  
Health Studies Higher Degrees Committee  
College of Human Sciences  
ETHICAL CLEARANCE CERTIFICATE**

HS HDC/322/2014

Date: 30 January 2014 Student No: 0582-632-2  
Project Title: An Ethnographic study cultural practices that may promote or hinder the spreading of HIV/AIDS in the Tsonga Community.  
Researcher: Lynette Fanisa Baloyi  
Degree: D Litt et Phil Code: DPCHS04  
Supervisor: Prof AS van der Merwe  
Qualification: PhD  
Joint Supervisor: -

**DECISION OF COMMITTEE**

Approved ☒

Conditionally Approved ☐

**Prof L Roets**  
**CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

**Prof MM Moleki**  
**ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

## ANNEXURE B: Mpumalanga Health Department Ethics Application Letter



No.3, Government Boulevard, Riverside Park, Ext. 2, Mbombela, 1200, Mpumalanga Province  
Private Bag X11285, Mbombela, 1200, Mpumalanga Province  
Tel I: +27 (13) 766 3429, Fax: +27 (13) 766 3458

Litiko Letemphilo

Departement van Gesondheid

UmNyango WezeMaphilo

Enquiries: Themba Mulungo (013) 766 3511

02 December 2015

**Ms. Lyenette Baloyi**  
**P.O. Box 596**  
**THULAMAHASHE**  
**1360**  
**South Africa**

Dear Ms. Lyenette Baloyi

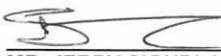
**APPLICATION FOR RESEARCH & ETHICS APPROVAL: AN ETHNOGRAPHIC STUDY:  
CULTURAL PRACTICES THAT MAY PROMOTE OR HINDER THE SPREADING OF  
HIV/AIDS IN THE TSONGA COMMUNITY**

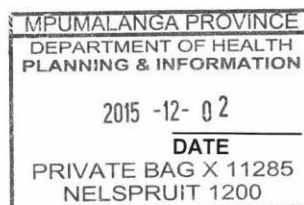
The Provincial Health Research and Ethics Committee has approved your research proposal in the latest format that you sent.

**PHREC REF: MP\_2015RP16\_810**

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

  
**MR. JERRY SIGUDLA**  
**RESEARCH AND EPIDEMIOLOGY**



## ANNEXURE C: Mpumalanga Health Department Permission

29-12-15:14:47

10137080000

# 2 2



health  
MPUMALANGA PROVINCE  
REPUBLIC OF SOUTH AFRICA

R583 Kruger Hazyview, Kruger National Park Road, Hoxans Multi-purpose Centre,  
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Lisiko Lelamphilo

Dopartemeni van Gesondheid

UmkhayaWezeMaphila

BNQ: M5 KHOZA V.L  
EXT: 119

TO: MR MATHEBULA H.R  
HR MANAGER


FROM: KHOZA V.L  
SENIOR PERSONNEL PRACTITIONER: HRD

DATE: 29 DECEMBER 2015

RE: APPROVAL TO DO A RESEARCH PROJECT- ON ETHNOGRAPHIC STUDY: CULTURAL PRACTICES THAT MAY PROMOTE THE SPREAD OF HIV /AIDS IN TSONGA COMMUNITY

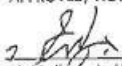
This letter serves to request approval for Mrs Lynette Fanisa, Baloyi to do a research project at all seven local areas under Bushbuckridge sub-district Mpumalanga, the research will start on the 2<sup>nd</sup> of January 2016.

The applicant is a part time student of University of South Africa; she will visit PHC facilities of Bushbuckridge Sub-district and the pilot site will be Hazyview clinic. There will be no blood test done for this study, the results for this research will be summarised and send to Mpumalanga Provincial office and Bushbuckridge Sub-district.

  
Ms Khoza V.L  
Senior Personnel Practitioner  
BBR Sub-district

29/12/15  
DATE:

APPROVED/ ~~NOT APPROVED~~

  
Mr Mathebula H.R  
HR manager  
BBR Sub-district

29/12/15  
DATE:

## **ANNEXURE D: Informed Consent Form**

**Baloyi LF 05826322 Ph.D. candidate UNISA STUDENT**

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### **CULTURAL PRACTICES AND BELIEFS AFFECTING HIV AND AIDS MANAGEMENT AMONG TSONGA PEOPLE IN BUSHBUCKRIDGE.**

- In signing this document, I give consent to be interviewed by a researcher/ to participate in an interview.
- The researcher is a professional nurse employed at the Nursing School in the catchment area of Bushbuckridge, Mpumalanga.
- I understand that I will be part of a research study that will focus on the perspectives of Tsonga people and the media on cultural practices that may promote or hinder the spreading of HIV/Aids.
- The study hopes to help the community and the Department of Health to better support communities to prevent and manage the devastating effects of HIV/AIDS.
- I understand that I will be interviewed in a private area in the clinic /at home., I will be asked several questions about my understanding, experiences, and perspectives about Tsonga culture and that the interview will take about an hour to complete.
- The nature of the study warrants the researcher to use audiotape to capture all the information that will be discussed during data collection,
- A field worker will be involved to assist in the process of audiotaping.
- I know that the interview process will be recorded but that my name and identity will be protected – no finding will be traceable to my individual contribution.
- No blood tests are involved in the study, and no issues of one's HIV status are discussed in the study.
- I have been informed that the interview is entirely voluntary and that even after the interview begins, I may refuse to answer any questions or decide to terminate the interview at any point. I have been informed that my answers to questions will not be given to anyone else, and reports of this study will not identify me. I have been

informed that my refusal to participation or refusal to participate will not have any effects on the service that I may require now or in the future.

- My participation in this study does not imply any financial reimbursement.
- I am aware that the results of his study will be given to me. If I need to, I can contact Ms. Lynette Fanisa Baloyi, anytime during the study using 0847422833 or or 013-773-0062 and baloyifl@webmail.co.za
- I understand that the researcher may contact me for more information in the future.
- The study has been explained to me, I have read and understood the consent form, and I am satisfied with all the information explained to me about the study, I agree to participate, and I understand I will be given a copy of this signed consent form.

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Signature of participant

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Date

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Signature of investigator

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Date

## **ANNEXURE E : CONSENT FORM FOR USING AUDIO RECORDER FOR DATA COLLECTION**

**LYNETTE FANISA BALOYI, Ph.D. STUDENT NUMBER O582-632-2.**

- This document seeks to confirm that I was given information regarding research “CULTURAL PRACTICES AND BELIEFS AFFECTING HIV AND AIDS MANAGEMENT AMONG TSONGA PEOPLE IN BUSHBUCKRIDGE”.
- I have also been explained about the need to use the audiotape for data collection during the study.
- In view of data for qualitative research and ethical issues around the recording of information, I agree that the researcher can make use of an audiotape during gathering of information
- I also understand that this data will be stored by the researcher.
- I am aware that I have the right to withdraw my consent at any time of the study without any consequences or penalty.
- I declare that I am involved in the study following full understanding of the study and after having been given adequate time to ask questions regarding this research.
- I, therefore, declare that I am ready to be involved in this study in which audio recording forms are an important component of the whole process of this study.

Informant/respondent

_____	_____	_____
PRINTED NAME	SIGNATURE / THUMB PRINT	DATE

I \_\_\_\_\_ (RESEARCH /FIELD ASSISTANT) hereby confirm that the above respondent has been given full information regarding the type of the study and the necessity of utilization of audio tape for the above mentioned study. Study researcher

_____	_____	_____
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PRINTED NAME

SIGNATURE

DATE

## **ANNEXURE F: INTERVIEW GUIDE FOR KEY INFORMANTS**

**TITLE:** CULTURAL PRACTICES AND BELIEFS AFFECTING HIV AND AIDS MANAGEMENT AMONG TSONGA PEOPLE IN BUSHBUCKRIDGE.

1. Kindly share with me the Tsonga cultural practices and beliefs that may increase the risk of HIV infection among Tsonga people in Bushbuckridge?
2. What do you think could be done to mitigate cultural practices and beliefs that negatively affect the management of HIV and AIDS among Tsonga people in Bushbuckridge?
3. What approach could be more relevant for managing HIV and AIDS for Tsonga people in Bushbuckridge?



**ANNEXURE G: TRANSCRIPT FOR DATA CAPTURED DURING INTERVIEW – KEY INFORMANT 14.**

**Interviewer** : **Lynette Baloyi**

**Duration of interview** : **27m33s**

**Gender of key informant** : **Male**

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**Lynette** : I have few questions that I want you to answer to the best of your knowledge. The first question is; *“Kindly share with me the Tsonga cultural practices and beliefs that may increase the risk of HIV infection among Tsonga people in Bushbuckridge.”*

**Informant** : There are many Tsonga cultural practices that can contribute towards the spreading of HIV, but I have chosen to talk about the following. The one that I want to talk about is the one where people are doing traditional incisions and tattoos (**leyi ni ngo I ku tlhavela tinhlanga kumbe swibayana hi Xitsonga Vanhu va fanele va bomba**). Europeans call these tattoos. For us in Xitsonga they are done on the face and some parts of the body. This is where a Tsonga woman who has these tattoos are meant to characterise a women and it was their way of making themselves beautiful and stand out from the other women. The other second cultural way in which HIV can be spread is through the traditional incisions (**I ku qhava – I ku tlhavela na kona**) and this is done by the traditional healers for medication after they have diagnosed a person from certain diseases and decide that you need the traditional incisions as treatment. The danger of these traditional incisions are that they are done using the razor blade and one razor blade is used for many people. And the same thing for “traditional incisions **“tinhlanga”**”, they use one needle for many people it is not changed.

Then there is this one that I don’t know much about, the elderly women, traditional birth attendants (**masungukati**) know very well

how they do it; but it carries a certain danger because it is a practice that is done when they are helping a pregnant woman to deliver the baby. **During that delivery process, traditional birth attendant don't use western things, they don't use gloves to protect themselves,** a woman is being assisted in any way and there can be exchange of blood or contact during that process or blood can spill.

And the fourth one that is contributing towards the spreading of HIV is when boys go for traditional circumcision (**loko vafana va ya engomeni**) when they are cut, only one blade is used for many initiates. Using one blade for many initiates is dangerous because some of the initiates have diseases even though they go for traditional circumcision while they are young, some of them come being HIV infected even though they are still young as they were born HIV positive. So during that circumcision, some initiates may be infected with HIV.

And the fifth one which can be affecting most of us and we may not be aware of it, is through shaving hair using the same razor blade that has been used before. What happens in our Tsonga culture is that if there was death in the family, (**loko ku loviwile hi Xichangana, kumbe hi Xitsonga vana hinkwavo na hinkwenu la mutini mi fanele mi byevula**) all the children in the family and everyone has to have their hair shaved and they use one razor blade to shave hair. So because they are using the same razor blade to shave hair, accidents happen and sometimes the skin may be cut and there will be bleeding while they were being shaved; and in that way HIV can spread from one person to another.

Another cultural practice that is contributing to the spreading of HIV is when a woman has lost her husband and one of her late husband's brothers has to inherit her as a wife (**loko munhu wa xisati a loveriwile a ngzeniwa**) A brother has to marry her to inherit the wealth. That wife inheritance can also contribute to the spreading of HIV epidemic.

And the other seventh thing there that happens is also the practice of cleansing rituals (**munhu u fanele a basisiwa loko a loveriwile**), they

don't care who comes to perform the cleansing rituals; anyone can do it especially nowadays because those people who do it are paid to do the cleansing rituals. Then one cleanser can go all over to do cleansing ritual. So those people do cleansing ritual for the sake of getting money, this person is only happy to be paid, meanwhile some of the people that they are cleansing are HIV positive and they don't tell him what was the cause of death or they don't know what killed the person (husband) they are doing the cleansing ritual for. So in the process that person (cleanser) can be infected and also infect other people while in the process of performing the cleansing rituals. So these are the practices that we do as the Tsonga people and they contribute to the spread of HIV.

And when it comes to the proverbs and idioms that are encouraging the spread of HIV, there is one proverb that is common is found in almost all the African languages. There is one that says "**wanuna i n'hwembe wa nava**" and some may say "**wanuna i xihloka ha lombisana**", they say that you cannot use an axe to cut alone; you need to borrow those who need it and want to use it as well. What they mean with "**wanuna i n'hwembe**" (pumpkin plant) it means that a man is allowed to spread to other families and have multiple relationships with women (**na vona va ta khatlula nhloko, hi leswaku wanuna u va a ri na mindyangu-ndyangu yo hambana- hambana kumbe swigangu -gangu swo hambana- hambana "wanuna i n'hwembe**). And men who don't have multiple partners are viewed as idiots and they are laughed at in the community, you are regarded as not being man enough, to avoid being laughed at so you need to spread and have several relationships so that one can fall in "that" group. And the more one spreads "**a nava**" and have those multiple relationships; it is the more one can contract the diseases (HIV).

And in our Tsonga culture when we say this is a man "**munhu loyi i wanuna loyi**" we refer to a man as a real man if he has lot of cattle, many wives, many children,; that man is given the status of being a man "**se u vuriwa ndhoda i wanuna, mani na mani loko a n'wi langutile wa n'wi vona kuri loyi a ko va xinuna-nunana i wanuna, i**

**mnumzana**". So lot of men want to be referred as such ,they then have multiple partners because they want to claim the status of being called "real man" and having married lot of women And to prove that this is real, even the surnames have meanings.

For example, the Nkuna surname (clan) they praise themselves by saying "**hi vona va ka mavuta a yi twile**" meaning that they don't marry a woman and settle down with her without engaging in sexual activities with her before marriage; instead they engage in sexual activities with different women before they can settle down. And by so doing, you are not going to try with one woman ,you are going to try and compare, comparing those women and in the end or later after several sexual encounters you then decide to choose amongst all the women the one who is better then you marry her. So that is what they mean when they say "**u vuta se u yi twile**"

If we look at the statistics of Russia, it is said that there are many women than men and it is the same with us as Africans or as the Shangaan people there are more women than men. So because of that, you find that it is no longer men that hunt women, but women are the ones who look for a man because they say a man is not meant for one woman "**wanuna i wanuna wa munhu un'we xana na?,a wu nge vi wanuna wa munhu un'we, hina Van'wana hi ta n'wi kuma kwini ?**". So if women say that, they are putting themselves on the shelves or advertising themselves and they are spreading HIV in the community in that way as well. So in that way men prove themselves to be the real men by having multiple relationships "**se ku komba leswo wa hanya u fanele u va wanuna wa vanhu hinkwavo**".

And people also say "**homu l homu loko yi yimile, hi leswo loko yi karhi yi yimile hi ri homu hi liya ,loko yo tshika yi wile se yi hundzuka nyama hikuva se ya dyiwa**" meaning that a person is seen as a good person in daylight but at night when they get together in the house they don't care what they do and they don't care if they practice safe sex /they are protected or not "**homu l homu loko yi yimile,loko yi wile l nyama**".

**Lynette :** Okay, are there any songs that you know that are also encouraging the spread of HIV in this community of Bushbuckridge?

**Informant :** When it comes to the songs, I can only think of one song for now. And the lyrics to the song that I remember goes like this ***“nsati wa ku cinga na wa ku lovola ku wina mani?”*** and it means that between a widow and a woman who is not a widow the one who wins is the widow because the widow has wealth such as having a kraal of cattle, her money, her cars, and so forth that she has inherited from her late husband unlike the one who has not lost a husband. The song goes like this *(participant sings)* ***Nsati wa ku cinga na wa ku lovola ku wina mani? Ku wina wa ku cinga ,a nga na yini a nga na xivala xa tihuku na timbhongolo a Fanta ge !*** *(Referring to cold drink Fanta)* She wins. So they mean that a woman whose husband is still alive is not considered because she still has to take care of her husband than the widow because she is free and she is able to entice men because she has money and she can do almost everything for men. ***“U ta ku endlela, wa dyisa kahle-kahle”Wansati wa ku cinga na wa ku lovola ku wina wihi,ku wina lo wa ku dyisa”.***

**Lynette :** Meaning that she wins because they want the wealth that she has inherited from her late husband?

**Informant :** Yes, because men will go to her claiming to love her meanwhile they know very well that they are after her wealth. And because she attracts a lot of men, the more men go to her; for those several men, there is a possibility that they get involved in activities which may lead them into contracting the diseases ***(va oka vuvabyi)***.

**Lynette :** Okay. so what can you recommend as a way of fighting against the spreading of HIV when it comes to those cultural practices?

**Informant :** I can say that to fight against the spread of HIV or to remedy this is to avoid doing all those things that I have mentioned in short. And what is more important is that we should reinforce education on women and men about the various ways in which HIV can spread. We know that sharing food and kissing does not spread HIV they must know precisely ... and even using the same toilet does not spread

HIV...people should be informed about what exactly spreads HIV and what does not spread HIV, this spreads HIV and this does not spread HIV. And we should maybe stop with the cultural practices, the prescripts of tradition because these practices are exposing people to HIV, for instance a person should not protect herself during the cleansing rituals and the wife inheritance because they don't check to know what caused that person to die. So we should let go of all those practices and behaviours because they are dangerous to people's health.

And one other thing is that people should not allow traditional healing to tempt them. There are people that say they cannot manage to take the HIV treatment for the rest of their lives, rather they choose the shortcuts and they are given traditional medicines to use and they forget that medicines are issued by traditional healers because it is bringing in money. The traditional healers care about money rather than the person's health/life. There are even street vendors that are selling medicines and they claim that they are able to cure chronic diseases. And for instance, when you look at the households where there is an elderly person, there is a *Moringa* tree because elderly people believe that this tree is able to cure various diseases. Then there are some people that believe that the medicines from China is able to treat diseases and they forget that those people are only interested in making money. I think that if we can have the Western medical systems, they can help us in a way because they have been tested before to see if it works or not. They are not only using those medications on few people because it produces income...

**Lynette :** There has been an in depth research on them.

**Informant :** Yes, there has been a thorough research. And when it comes to the barbershops that we visit to shave our hair, we have a problem, we don't check or observe to see what did they do, if the machine (instruments) that they are using for shaving are sterilized or not. People are getting in one after the other for shaving and in most cases one razor blade is used...and as customers we don't care to know if it

is safe or not. The only thing the customers care about is to look good and neat after shaving, not their health. And when they shave, what matters is that a person should come out having “chiskop”

**Lynette :** Okay, thank you. You have talked about the proverbs that encourage men to have multiple relationships and you have given an example of one proverb that says “**wanuna wa nava i nhwembe**”, do you think the youngsters or the male teenagers are also encouraged to have multiple partners or how do young people take it ?

**Informant :** Mmmm, there are things that we use, called taboos and as people we believe them to be true without doing any research on them or any reasoning around them. For instance, our parents used to tell us that we must not roam around the streets at night because we will meet ghosts, once we were told it is taboo, we were doing as they were telling us without questioning it. They would also tell us that we must not whistle at night because you will lose your voice or your mouth will be skewed, we never questioned that, once they said it is taboo we believed them because they were said to be superstitions or taboos and they were true. So the same goes for our proverbs because we are told something and we have to believe them because we have been indoctrinated .It is through indoctrination that a person is told about something and then strongly believe that thing (taboo) “**munhu u byeriwa xo karhi a khomelela**”If you can observe well, even churches do the same because **some churches convince the congregants and say we will heal you , they tell them that they will give them water and oil that whatever they are giving them has the healing powers and people want what they can have now, “Munhu wa ntimu u lava leswi a swi khomaka hi voko .”** So even if benefits are there or not there, we want things now- now.

So when it comes to that proverb “**wanuna wa nava**” , the men’s joy is that they will have many wives and they will be popular; they don’t care to know as long as that one is yours and that one also is yours, where they are going to contract the diseases is immaterial .What a person wants is that all these women are mine They used to mock a

reverend of the Zion church .You would find him alone in church with lots of women, there was this song that was sung by the Zionists, I don't know how true it is; but it was said that the head of the church wearing the white gown would sing "**bonke la bafazi nga bami**" (all these women belong to me) and the women would sing in response "**yebo baba mufundisi**" (to confirm what he was saying). So that shows that men are only proud to have many women as his partners without caring about the effects of that. The after effects are immaterial.

**Lynette** : They don't care about the effects of those relationships?

**Informant** : No, the only focus is "what is my gain now". Actually I think that there are three things that men want on this planet, money, and fame, through money they will become famous and with fame they will lure lot of women easily. So those are the three things that are important to men.

**Informant** : Yes, money first, you must have money, followed by fame and fame will be followed by many women who will be yours.

**Lynette** : Okay, do you think that the people of Bushbuckridge; the Tsonga speaking people in particular...do you think they still think it is very important for them to practice that culture like the wife inheritance, the cleansing rituals and the shaving of hair after the burial? If people feel strongly about the importance of those cultural practices, what can you recommend as a way of modifying some of these Tsonga cultural practices?

**Lynette** : Okay, you have recommended that people can go along with their own razor blades when going to the traditional healers; what do you recommend for traditional circumcision?

**Informant** : I can recommend that for shaving they should not be lazy, even to make traditional incisions for treatment they should not be lazy to buy many razor blades or they can say the one who is coming for shaving also bring along his/her own razor blade even if you are going to use it twice or three times it is your own razor blade ,bring your own



razor blade or you are going to shave hair with a machine, bring your own machine, everything even things such as toothbrush ,do not brush your teeth with the same toothbrush just because you love each other . For traditional male circumcision even if they cannot bring along their own blades because it might happen that traditional circumciser rejects the razor blades that the initiates bring along, but he should make sure that he buys enough razor blades so that he cannot use one blade on many initiates. If he has five initiates, he should buy five razor blades and if he has ten initiates, ten razor blades should be bought. The same with the nurses at the clinics and the hospitals, they are using one injection for each patient; the same should apply for them as well. I don't believe that in this way HIV spreading cannot be reduced, it can be prevented.

**Lynette :** And we don't want HIV to spread. Is there anything else that you want to add that you think can help in the fight against the spread of HIV? It can be anything that is done from the time a child is born, when growing up to becoming teenagers and towards becoming adults all the way to when they reach old age. Is there anything that you think needs to be modified here in our community of Bushbuckridge to prevent the spread of HIV?

**Informant :** The problem is that we do many things in a way that we feel that we are showing love to the people around us. What I am going to say now is not necessarily something that spreads HIV but what I have observed is that people share a drink from the same calabash, I mean you find about ten people drinking from the same calabash. We have the problem of communal use of amenities. We want to share everything as a sign of love, one drinks with their beard inside the calabash and they wipe afterwards and pass it on. What I am trying to say here is that as people of Bushbuckridge, we want to share almost everything because we claim to love each other in that way not caring whether we are spreading the diseases or not. It is not only HIV/AIDS that spreads in that manner; some other diseases can also spread in that way. Even in our households we share the same bath soap and we are not showing love in that way, instead it is thriftiness because

we don't want to waste things. Another thing that we have adopted from the western culture is the basin, I think the showers are much better compared to sharing the basins. Even though we say that it is not possible for HIV to spread through sharing food, but it is very possible for HIV to spread through sharing the basin.

**Lynette** : One last question sir, is there anything that you know in raising a girl child that can predispose her into HIV; I mean anything that is cultural related?

**Participant** : I don't know exactly what happens when the girls attend the traditional initiation schools, but I have a suspicion that they must be made to do something which is communal and they can be sharing the resources. So if that is the case, they should make sure that each girl uses their own resources.

**Lynette** : Okay, thank you. I think you have given me detailed answers to all the questions that I had from the ways in which we can prevent HIV and eliminating the spread. Thank you very much and I hope this information that you have given me will be useful for me to proceed with the research.

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***End of interview***

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